Texas Works Handbook

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A—111 Pre-Application Process

Revision 15-4; Effective October 1, 2015

TANF

Before the Application process begins, staff deliver an up-front Texas Works message to the Temporary Assistance for Needy Families (TANF) applicants explaining that:

- TANF is temporary and has time limits;
- there are other alternatives and options for the applicant instead of TANF benefits;
- an applicant should consider jobs and other resources (such as child support) before pursuing TANF;
- if an applicant chooses to apply for assistance, the individual is requesting help finding a job; and
- even if an applicant chooses not to apply for TANF, the individual still may apply for Medicaid and the Supplemental Nutrition Assistance Program (SNAP) to support employment while working toward self-sufficiency.

Staff must consider and determine which messages are appropriate for a particular applicant.

A—112 Application Assistance

Revision 15-4; Effective October 1, 2015

All Programs

If an applicant needs help completing the application packet, a volunteer or staff member must help. Anyone helping the applicant complete a paper application must initial the completed sections or sign the form showing that a volunteer or staff person helped complete the application.

A—113 Application Requests and Submissions

Revision 15-4; Effective October 1, 2015

All Programs

Applications must be given to anyone who requests the form. Each household has the right to file an application on the same day the household contacts the office during office hours. The local office must ensure that a person can obtain an application packet within 15 minutes of coming into the office.

Staff must advise the household that an applicant does not have to be interviewed before filing the application. The household may file an incomplete application as long as the form contains the applicant's name, address, and signature as explained in A-121, Receipt of Application.

Program	Ways to Request an Application*	Ways to Submit an Application	Applications
TANF	• Online through YourTexasBenefits.com; • In the local office; • By mail; • By fax; or • By phone.	• Online through YourTexasBenefits.com; • In the local office; • By mail; or • By fax.	• YourTexasBenefits.com • Form H1010, Texas Works Application for Assistance — Your Texas Benefits: ◦ Staff must also provide the following forms with the application: ▪ Form H1830, Application/Review/Expiration/Appointment Notice; ▪ form VR30, Texas Voter Registration Application; ▪ Form H0050, Parent Profile Questionnaire, for each absent parent; ▪ Appropriate program pamphlets; and ▪ A postage-paid return envelope.
SNAP	• Online through YourTexasBenefits.com; • In the local office; • By mail; • By fax; or • By phone.	• Online through YourTexasBenefits.com; • In the local office; • By mail; or • By fax.	• YourTexasBenefits.com • Form H1010, Texas Works Application for Assistance — Your Texas Benefits: ◦ Staff must also provide the following forms with the application: ▪ Form H1830, Application/Review/Expiration/Appointment Notice; ▪ form VR30, Texas Voter Registration Application; ▪ Appropriate program pamphlets; and ▪ A postage-paid return envelope. **Note:** Form H1805, SNAP Food Benefits: Your Rights and Program Rules, must be included in the application packet or given to the applicant during the interview.
Medical Programs	• Online through YourTexasBenefits.com; • In the local office; • By mail; • By fax; or • By phone.	• Online through YourTexasBenefits.com; • In the local office; • By mail; • By fax; or • By phone.	• YourTexasBenefits.com • Form H1010, Texas Works Application for Assistance — Your Texas Benefits: ◦ Staff must also provide the following forms with the application: ▪ Form H1830, Application/Review/Expiration/Appointment Notice (if applicable); ▪ form VR30, Texas Voter Registration Application; ▪ Appropriate program pamphlets; and ▪ A postage-paid return envelope. • Form H1205, Texas Streamlined Application: ◦ Staff must also provide the following forms with the application: ▪ Form H1830, Application/Review/Expiration/Appointment Notice (if applicable); ▪ form VR30, Texas Voter Registration Application; ▪ Appropriate program pamphlets; and ▪ A postage-paid return envelope.

* Staff must give the applicant an application on the same day it is requested. If a household contacts the local office by telephone and does not wish to come to the designated office to file an application on the same day of the request and prefers receiving the application by mail, staff send an application packet on the same day of the telephone request. For written requests, including those received electronically or by fax, staff mail an application packet on the same day the request is received.

The Texas Health and Human Services Commission (HHSC) must accommodate reasonable requests to receive communications by alternative means or at alternative locations. The individual must specify in writing the alternate mailing address or means of contact, and include a

statement that using the home mailing address or normal means of contact could endanger the individual.

Note: Individuals applying for Medical Programs may also use the Marketplace-only applications explained in A-113.1, Application Forms. These applications can be submitted to HHSC in person, by fax, by mail, or via an account transfer explained in A-118, Coordination with the Federal Marketplace.

Related Policy

Registering to Vote, A-1521

A—113.1 Application Forms

Revision 19-4; Effective October 1, 2019

YourTexasBenefits.com

The online application on YourTexasBenefits.com integrates HHSC programs into one single application flow. Applicants only see the questions relevant to the programs they request. A PDF copy of the application information is created for applicants and staff to view.

YourTexasBenefits.com can be used to apply for the following benefits:

- SNAP food benefits;
- TANF cash help for families;
- health care for:
  - children;
  - adults caring for a child;
  - adults not caring for a child (if this is selected, YourTexasBenefits.com will allow applicants to identify themselves as a refugee; if they are not a refugee, they will be redirected to HealthCare.gov);
  - pregnant women;
  - people age 65 or older or with a disability; and
  - people under age 26 who were in foster care in Texas and receiving federally funded Medicaid at age 18 or older; and
  - people under age 21 who were in foster care in Texas or had an Interstate Compact on the Placement of Children (ICPC) agreement at age 18 or older;
- Medicare Savings Programs; and
- long-term services and supports for:
  - people with intellectual or developmental disabilities; and
  - people with no intellectual or developmental disabilities.

Form H1010, Texas Works Application for Assistance — Your Texas Benefits

Form H1010 integrates Texas Works programs into one single application.

The addendum to Form H1010 — Form H1010-M, Applying for or Renewing Medicaid or CHIP? — captures the information needed to make an eligibility determination for Medicaid or the Children's Health Insurance Program (CHIP).

Form H1010 can be used to apply for the following benefits:

- SNAP food benefits;
- TANF cash help for families; and
- health care for:
  - children;
  - adults caring for a child;
  - adults not caring for a child;
  - pregnant women;
  - people under age 26 who were in foster care in Texas and receiving federally funded Medicaid at age 18 or older; and
  - people under age 21 who were in foster care in Texas or had an ICPC agreement at age 18 or older.

Form H1205, Texas Streamlined Application

Form H1205 can only be used to apply for health care benefits.

Form H1205 can be used to apply for the following benefits:

- health care for:
  - children;
  - adults caring for a child;
  - adults not caring for a child;

- pregnant women; and
- people under age 26 who were in foster care at age 18 or older; and
- people under age 21 who were in foster care in Texas or had an ICPC agreement at age 18 or older.

Applications Solely Used by the Marketplace

The online Marketplace application is a single interactive application based on an applicant's selections. In addition, there are three paper applications for the Marketplace:

- **Application for Health Coverage** — for anyone who needs health coverage, but does not need help paying for health insurance costs.
  - Used by applicants who want to purchase a Qualified Health Plan (QHP) through the Marketplace.
- **Application for Health Coverage & Help Paying Costs (Short Form)** — for single adults who need help paying for health care coverage (mostly for states offering Medicaid expansion coverage to single adults ages 19 through 64) and who:
  - are not married, do not claim any tax dependents, and cannot be claimed as a tax dependent on someone else's federal income tax return;
  - were not formerly in the foster care system; and
  - are not American Indian (AI)/Alaska Native (AN).
- **Application for Health Coverage & Help Paying Costs** — for anyone who needs help paying for health care coverage, including:
  - people who are married, have tax dependents, or can be claimed as a tax dependent on someone else's federal income tax return;
  - people with or without current health care coverage;
  - families that include immigrants; and
  - people who were formerly in the foster care system.

Since these applications do not contain additional questions that were included on Form H1205, Texas Streamlined Application, send out Form H1020, Request for Information or Action, to request any additional information necessary to make an eligibility determination.

A—114 Applications Causing Conflicts of Interest

Revision 15-4; Effective October 1, 2015

All Programs

The advisor must avoid the appearance of impropriety or conflict of interest when determining eligibility. The advisor is not allowed to work on a case if the individual is a relative (by blood or marriage), roommate, dating companion, supervisor, or someone under the advisor's supervision. The advisor may never work on a case in which the advisor is a case participant or an authorized representative (AR).

The advisor:

- may provide anyone with an application and information about how and where to apply for benefits;
- may help a person gather any documents needed to verify eligibility; but
- must not take any other role in determining eligibility.

The advisor must consult with the supervisor if the individual is a friend, acquaintance or coworker. Generally, the advisor should not work on cases involving these individuals, but the degree and nature of the relationship should be taken into account. In remote areas where it is impractical for another person to process the application, the unit supervisor should be contacted to determine the best method to process the application.

A—114.1 Applications Submitted by Texas Works or Medicaid for the Elderly and People with Disabilities Employees

Revision 18-1; Effective January 1, 2018

All Programs

Give special handling to applications and redeterminations submitted by Texas Works and Medicaid for the Elderly and People with Disabilities employees.

- A Texas Works or MEPD employee at the next higher administrative position must complete the eligibility determination for another Texas Works employee.
- A designated supervisor must complete the eligibility determination for a Texas Works or MEPD supervisor or higher position.
- The employee's immediate supervisor or someone in the direct line of supervision may not process the Texas Works or MEPD employee's application.

A—115 Applications Filed in Hospitals and Clinics

Revision 19-1; Effective January 1, 2019

All Programs

Facility work is the primary assignment for Outstationed Worker Program (OWP) staff. Staff will process workload following the OWP Hierarchy order below:

- OWP Lobby Facility Workload
- OWP Statewide Facility Workload
- Regional EWMS Teams (Supplemental) Workload

Staff follow the most current business processes found in the Eligibility Operations Procedures Manual to complete this workload.

The file date is the date HHSC receives the application from the contracted facility.

A—116 Special Application Processes

Revision 12-2; Effective April 1, 2012

A—116.1 Reserved for Future Use

Revision 20-2; Effective April 1, 2020

A—116.2 Applications from Residents of a Homeless Shelter

Revision 22-1; Effective January 1, 2022

SNAP

People staying in homeless shelters are potentially eligible for SNAP, regardless of the number of meals the facility provides, if the homeless shelter is an approved institution. A homeless shelter is an approved institution if it is a:

- public or private, nonprofit shelter for the homeless; or
- certified SNAP retailer.

Verify the homeless shelter is an approved institution, if questionable.

People staying in homeless shelters that are not approved institutions are potentially eligible for SNAP if the facility provides half of their meals or less. Consider this when determining if a person staying in a facility is institutionalized.

Homeless households must meet the same household composition, income, and resource standards as other households. If the household pays for room in a shelter, consider the payments as shelter expenses.

Related Policy

Nonmembers, A-232.1
Prepared Meals for Homeless, B-462
Homeless Shelter Standard, A-1427
Determining Whether a Person Who Resides in a Facility Is Institutionalized, B-490

A—116.3 Applications for Babies Born to Women in Prison

Revision 15-4; Effective October 1, 2015

Medical Programs

A pregnant woman who enters the state prison system is sent to the Texas Department of Criminal Justice women's facility. Before the baby is born, the prison social worker assists the pregnant woman to arrange for a responsible individual to pick up the baby from the hospital. The pregnant woman is sent to a prison section of the University of Texas Medical Branch (UTMB) in Galveston a few weeks before she is due to deliver, unless an emergency occurs earlier. If an emergency does occur, she will deliver at a closer facility when necessary. Before releasing the baby from the hospital, UTMB requires the individual who picks up the baby to complete an application for Medicaid. Designated Texas Works advisors ensure that the baby is certified for Medicaid using special application processing procedures and follow-up activities.

The designated advisors coordinate Medicaid certification by other advisors in special situations when the newborn needs to be added to an active case. Upon request by the designated advisors, which must be documented in the case record, an advisor must certify the newborn:

- for Medicaid (TP 43) from the date of birth (DOB), not the day the caretaker brought the baby home from the hospital; or
- after normal application time frames have passed. If needed, staff may follow procedures to request a timeliness exception.

State law requires Medicaid coverage for Texas newborns for at least 28 days after birth and possibly longer if the child is hospitalized at that time. If the hospital followed required procedures before releasing the baby, but the baby does not meet eligibility requirements for Medicaid, the designated advisor and State Office Data Integrity (SODI) staff certify the baby for TA 62, MA - State-Paid Coverage. Examples of not meeting eligibility requirements are:

- the individual caring for the child does not reside in Texas, and the baby will be taken out of state;
- the individual caring for the child refuses to apply for Medicaid; or
- the household is over the income limit.

Related Policy

Documentation Requirements, A-190
Medical Programs, A-240

A—116.4 Reserved for Future Use

Revision 20-4; Effective October 1, 2020

A—116.5 Food Distribution Program on Indian Reservation (FDPIR)

Revision 11-3; Effective July 1, 2011

For application processing related to FDPIR, refer to the policy in B-421, Food Distribution on Indian Reservation (FDPIR).

A—116.6 Joint SSI-SNAP Applications

Revision 22-3; Effective July 1, 2022

For application processing related to joint Supplemental Security Income (SSI)-SNAP applications, refer to the policy in B-476, Joint Supplemental Security Income (SSI)-SNAP Applications.

A—116.7 Types of Assistance Administered by Centralized Benefit Services (CBS)

Revision 11-3; Effective July 1, 2011

A—116.7.1 Reserved for Future Use

Revision 22-3; Effective July 1, 2022

A—116.7.2 Applications for SNAP-CAP

Revision 15-4; Effective October 1, 2015

For application processing related to SNAP-CAP, refer to the policy in B-475, Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP).

A—116.7.3 Medicaid for Transitioning Foster Care Youth (MTFCY) (TP 70)

Revision 15-4; Effective October 1, 2015

For application processing related to MTFCY, staff should refer to policy in B-474.1.2, Medical Programs, 2; and Other Medical Programs, Part M, Medicaid for Transitioning Foster Care Youth (MTFCY).

A—116.7.4 Medicaid Coverage for Children Placed in or Released from a Juvenile Facility

Revision 20-4; Effective October 1, 2020

For application processing related to Medicaid for children placed in the custody of or released from the Texas Juvenile Justice Department or Juvenile Probation Department, refer to policy in B-543, Child Placed in a Juvenile Facility, and B-546, Notification of Actual Release from a Juvenile Facility.

A—116.7.5 Medicaid for Breast and Cervical Cancer (MBCC)

Revision 15-4; Effective October 1, 2015

For application processing related to MBCC, staff should refer to policy in B-474.1.2, Medical Programs, 4; and Other Medical Programs, Part X, Medicaid for Breast and Cervical Cancer (MBCC).

A—116.7.6 Reserved for Future Use

A—116.7.7 Former Foster Care in Higher Education (FFCHE) (TA77)

Revision 11-3; Effective July 1, 2011

For application processing related to FFCHE, refer to policy in Other Medical Programs, Part F, Former Foster Care in Higher Education (FFCHE).

A—116.7.8 Former Foster Care Children (FFCC)

Revision 15-4; Effective October 1, 2015

For application processing related to FFCC, refer to policy in Other Medical Programs, Part E, Former Foster Care Children (FFCC).

A—117 Applications Filed Online through YourTexasBenefits.com

Revision 15-4; Effective October 1, 2015

When the household submits an application online, a process formats the information entered on the online application and imports certain data into TIERS. The process creates the PDF file of the application that is stored in the image repository and is viewable in the State Portal.

TIERS edits the data passed by YourTexasBenefits.com. The fields must contain valid characters and be valid values to be imported into TIERS. Dates must be in the correct format, fields that are numeric must contain only numbers and data must be in accepted ranges for fields with values such as Yes or No, or ZIP codes.

Applications that do not contain required data or have data that may be invalid may be rejected. When an application is rejected for electronic processing into TIERS, the system creates a non-SSP Application Registration Task List Manager (TLM) task.

Applications that are valid and accepted as electronic input into TIERS have an Application Registration TLM task created for them. The task is routed to the appropriate office based on Type of Assistance (TOA) and individual ZIP code for the clerk to perform the Application Registration process task.

A—117.1 Application Registration

Revision 15-4; Effective October 1, 2015

Clerks select the Application Registration task and review the application. Staff will perform Application Registration using certain pre-filled data from the online application that was entered by the individual. All online applications must have Application Registration processed even if the case is approved. It is important to associate the online application to the existing case.

A logical unit of work (LUW) is in Application Registration; Self-Service Application Search. Clerks search for the self-service application using any of the fields in the search area. The search results will be displayed by the head of household name even when the search was not on the head of household.

After successful Application Registration, an appointment or process task will be created for Data Collection, depending upon the programs requested on the online application.

The Application T number is changed to a case number upon clicking Submit in Application Registration.

A—117.2 Data Collection

Revision 15-4; Effective October 1, 2015

When performing Data Collection, the data entered in the online application is displayed for the advisor either as:

- pre-filled TIERS fields and a message at the top of the page stating that the fields are pre-filled from self-service data (for new applications); or
- YourTexasBenefits.com information that must be addressed, which displays in a comparison pop-up window (existing cases).

Click on the C icon in the Details page to access the comparison pop-up.

The comparison pop-up window displays the current data in TIERS and the data from the online application to allow the advisor to select the correct data to use in Data Collection.

The advisor may choose to:

- accept all TIERS data,
- accept all YourTexasBenefits.com data, or
- select each data element to be used individually from the comparison pop-up.

These comparison windows are displayed on most Data Collection pages through Resources. There is no YourTexasBenefits.com information or comparison windows in the Program, Income or Expenses pages. The advisor must complete the Data Collection driver flow.

A screen is added in the driver flow just before Run Eligibility. This screen is a summary screen that displays each LUW with YourTexasBenefits.com comparison data and the status of that data. Once the case is disposed, all YourTexasBenefits.com comparison data that was not resolved or processed will be marked completed by the system.

A—118 Coordination with the Federal Marketplace

Revision 24-4; Effective Oct. 1, 2024

Medical Programs

Eligibility determinations for Medicaid must be coordinated with the federal Marketplace. A person who applies for health care coverage through the Marketplace at HealthCare.gov is also assessed for Medicaid eligibility. If the Marketplace assessment does not show the person may be eligible for Medicaid, the person can still request their information be transferred to HHSC for a full eligibility determination.

The Marketplace assesses a person as:

- potentially eligible for Medicaid based on Modified Adjusted Gross Income rules; or
- potentially eligible for Medicaid on a non-MAGI basis if the person is 65 or older or reports having a disability or blindness.

If the assessment shows the person may be eligible for Medicaid, the person's application information is transferred to HHSC.

HHSC must evaluate the person's eligibility for Medicaid without requiring a new application.

A—118.1 Applications Received from the Marketplace

Revision 24-4; Effective Oct. 1, 2024

Medical Programs

The federal Marketplace sends the information from a person's application to HHSC through an electronic interface when:

- the Marketplace assessment shows the person may be eligible for Medicaid; or
- the person requests a full eligibility determination for Medicaid.

The electronic transfer of information from the application is referred to as an account transfer. The account transfer includes information provided by the person on the Marketplace application and information verified by the Marketplace.

The account transfer process generates a PDF application with the information the Marketplace provides. Verifications completed by the Marketplace are included in the Verifications section of the PDF. Like an application from YourTexasBenefits.com, enter applicant information into the appropriate logical unit of work (LUW) following the policies for documentation and verification requirements. This includes any required documentation about blanks or discrepancies on the PDF application, and steps taken to resolve questionable information.

A—118.1.1 Non-MAGI Account Transfers

Revision 24-4; Effective Oct. 1, 2024

Medical Programs

A non-Modified Adjusted Gross Income (non-MAGI) account transfer is an account transfer sent from the Marketplace to HHSC. This is done when the Marketplace has identified that an applicant may be eligible for Medicaid for the Elderly and People with Disabilities (MEPD) because the applicant reported being 65 or older, having a disability or being blind.

HHSC must accept the Marketplace account transfer and evaluate the person's eligibility for Medicaid without requiring a new application.

A—118.1.2 Verifications Provided by the Marketplace

Revision 24-4; Effective Oct. 1, 2024

Medical Programs

Marketplace account transfer PDFs also include a Verifications section. Enter information from the verification section as follows:

- If the Marketplace verified the person's Social Security number (SSN) or citizenship status using data from the Social Security Administration (SSA), accept the information as Verified by SSA.
- If the Marketplace verified the person's alien status using data from the Department of Homeland Security (DHS), accept the information as Verified by DHS.
- If the Marketplace verified other eligibility criteria, such as income or resources, per HHSC verification policy, accept the information as verified.

Verify all other applicant information as required by the applicable HHSC verification policy. Do not request additional verification for information verified by the Marketplace per HHSC verification policy.

Related Policy

Verification and Documentation, C-900

A—118.2 Applications Sent to the Marketplace

Revision 24-4; Effective Oct. 1, 2024

Medical Programs

HHSC transfers the person's account information back to the Marketplace to be assessed for other health care coverage programs, if the person is:

- ineligible for Texas Works Medicaid or CHIP;
- eligible for TP 56, Medically Needy with Spend Down;
- eligible for TP 32, Medically Needy with Spend Down-Emergency;
- eligible for TA 41, Healthy Texas Women; or
- only eligible for three months prior Medicaid.

Send Form TF0001, Notice of Case Action, to inform the person their information was transferred to the Marketplace.

A—119 Correspondence Options

Revision 15-4; Effective October 1, 2015

A—119.1 Electronic Correspondence

Revision 15-4; Effective October 1, 2015

All Programs

The head of household or authorized representative (AR) for a case may each choose at any time to receive most eligibility correspondence electronically rather than through the mail. By selecting this option, applicable forms and notices are posted to the client's or AR's YourTexasBenefits.com case account, and the client or AR receives a cell phone text message or email reminder each time a new form or notice has been posted to their account. Clients may print a copy of the correspondence from their account or request that a paper copy be mailed to them. Any forms or notices that are not available electronically will continue to be mailed to the client.

Once a head of household or AR has opted to receive electronic correspondence through their case account on YourTexasBenefits.com or by indicating that preference to staff through 2-1-1 (Option 2), a confirmation cell phone text message or email reminder will be sent to the client. The head of household or AR must enter the code provided in that confirmation message in their YourTexasBenefits.com case account in order to confirm their choice to receive electronic correspondence. Once confirmed, Form H1013, Electronic Correspondence Confirmation Letter,

will automatically be mailed to the head of household or AR to further confirm the selection and to provide instructions about how to opt out of receiving electronic correspondence.

After a failed delivery of a text or email alert, the client is automatically unsubscribed from electronic correspondence. The eligibility system then automatically prints and mails to the client a paper copy of the correspondence that failed to reach the client with the original generation date, attached to Form H1015, Electronic Correspondence Failed Delivery. The client will receive future correspondence through the mail. However, the client may opt to subscribe again to receive electronic correspondence and start over the confirmation process.

A—119.2 Preferred Language for Correspondence

Revision 15-4; Effective October 1, 2015

All Programs

The head of household or AR for a case has the ability to choose the language in which certain forms and notices are generated from the eligibility system. The head of household or AR can select their primary household language from the following options:

- English
- Spanish
- Both English and Spanish
- Vietnamese*

* Clients who select Vietnamese as their primary household language will receive correspondence in English, and the eligibility system will automatically attach to the form or notice the Vietnamese Translation Interpreter Form, which directs clients to translation services.

Once a primary household language is selected, both the head of household and AR will receive correspondence in that language.

A-120, Office Procedures

Body

A-121 Receipt of Application

Revision 23-3; Effective July 1, 2023

All Programs

Applications must be signed under or on the same page as the penalty of perjury statement before certification.

TANF

An application is valid if it has the applicant's name, the applicant’s address, and the signature of the:

- applicant; or
- applicant's designated authorized representative (AR).

SNAP

An application is valid if it has the applicant's name, the applicant’s address, and the signature of:

- the applicant;
- another responsible household member; or
- the applicant's designated AR.

Medical Programs

An application is valid if it has the applicant's name, the applicant’s address, and the signature of any of the following people:

- the adult or minor applicant;
- the applicant's designated AR;
- an adult applying on behalf of a minor child; or
- a person 19 or older who:
  - is included in the applicant’s MAGI household composition; or
  - has a tax relationship with the applicant.

Note: Applicants are not required to live at the same physical address to apply for each other. For example, a non-custodial parent may apply for Medicaid and CHIP on behalf of their child if the parent expects to claim the child as a tax dependent on their federal income tax return.

TP 43, TP 44 and TP 48

Do not require a new application when a household has an active Medicaid type program and requests to add Medicaid for another child who needs a new EDG. Add the child to the case per additions to the household policy. **Exception:** Do not add more children to a case where a Medicaid EDG was reinstated due to the child's release from a juvenile facility. The household must submit an application for the other children. To identify these EDGs, view the **Individual – Medicaid History** page for the active child. If the Juvenile Placement History field indicates "Yes", the EDG has been reinstated.

This policy does not apply when there is no existing Children's Medicaid EDG. For example, do not add a child when the only other child is certified for Medicaid because the certified child receives SSI. A separate application is required to initiate coverage for the child being added.

Related Policy

Application Requests and Submissions, A-113
Filing the Application, A-122
Application Signature, A-122.1
Authorized Representatives (AR), A-170
Medical Programs, A-240
Children's Medicaid Redetermination Expectations, B-123.6
Denied EDGs, B-474.7
Additions to the Household, B-641

A-121.1 Receipt of Application from Residential Child Care Facility

Revision 24-1; Effective Jan. 1, 2024

Medical Programs

When a representative from a licensed residential child care facility applies for an independent child, accept and process the application.

A-121.2 Receipt of Duplicate Application

Revision 15-4; Effective October 1, 2015

All Programs

A duplicate application:

- is an application filed after another application has already been filed;
- does not include a request for programs different from programs requested on the initial application submitted;
- does not include a request for programs different from programs currently received by the applicant; and
- is not needed for a redetermination of any active program.

Example: If a household submits an application for SNAP on January 2 and later submits one or more additional applications for SNAP that are different from the one the household filed on January 2, and are not needed for a redetermination of any active program, the additional application submitted is considered a duplicate application.

Duplicate Application Received While Original Application Is Being Processed

If an office receives a duplicate application while staff are in the process of making an eligibility determination (an application or redetermination) based on the original application submitted, staff must:

- treat the duplicate application as a report of change; and
- assign the duplicate application as a change to the advisor currently processing the case.

The advisor processing the original application must:

- review the duplicate application for reported changes;
- document the duplicate application was reviewed for changes;
- document the type of changes, if changes were reported on the duplicate application; and
- use information provided by the household on both the original application and the duplicate application when determining eligibility for the household.

Duplicate Application Received After Original Application Is Processed

If an office receives a duplicate application and the applicant has already been certified for assistance based on another application previously submitted, staff must review the duplicate application to determine if the household is applying for programs other than what the household is currently receiving and if any redeterminations are due.

If the household is applying for different types of programs, the application is not a duplicate application and must be processed as a new application for assistance.

If the household is not applying for a different type of program and there are no redeterminations, office staff must:

- treat the duplicate application as a report of change; and
- assign the duplicate application as a change indicating "duplicate application."

Staff are not required to create a T number for TIERS cases and/or dispose of a duplicate application as "filed in error." If staff erroneously create a T number, staff must deny/dispose the T number as filed in error, in addition to other required actions listed above.

Note: If the office that receives the duplicate application does not normally process reported changes, staff may mark the application form as a duplicate application and route it to appropriate staff following local office procedures.

Advisors who process the duplicate application as a reported change must review the application to determine if any changes are indicated and take the following action. If no change is indicated on the duplicate application, the advisor must:

- document receipt of the duplicate application in TIERS Case Comments;
- route the duplicate application to be imaged as part of the electronic case record;
- sustain the benefits for each Texas Works program the household receives; and
- send an individual notice to the household that eligibility for benefits has not changed.

If a change is indicated on the duplicate application, staff must follow the procedures outlined in B-600, Changes, when processing changes reported on the duplicate application.

A-121.3 Receipt of Identical Application

Revision 15-4; Effective October 1, 2015

All Programs

An identical application is one or more exact copy of an application previously filed by an applicant.

Example: If a household faxes in an application on January 2 and later submits an exact copy of the same application, which includes the same signature and date of the application the household previously submitted, the newly submitted application is considered an identical application.

Required Action on Identical Application Received

If an identical application is received, staff must write "Identical Application" on the front page of the application and route the application for imaging. The vendor will image the identical application and add it to the electronic case record. No other action is needed.

A-122 Filing the Application

Revision 26-3; Effective July 1, 2026

All Programs

Staff should encourage households to file an application the same day the household or its representative contacts the office and shows interest in assistance. This includes contacts by phone, mail, fax or in person. Staff should explain how to file an application. Application forms are also available at YourTexasBenefits.com. They can be downloaded, printed and electronically submitted.

The file date is the day HHSC receives an application form which has the applicant's name, address and appropriate signature. This is day zero in the application process. Staff use this as the file date to determine eligibility for the programs the household requests upon filing the application through the time of the interview.

For applications submitted by phone through 2-1-1, the file date is the date the applicant submits the application with the applicant's name, address and telephonic signature.

The file date is the date the applicant clicks the Submit Application button in YourTexasBenefits.com, for electronically filed applications.

Exception: The file date is the next business day for all applications received outside of business hours when HHSC is closed, including weekends and holidays.

The household must file another application form to apply for more programs after the interview is held. This is even if the case was pended and is not completed at the time of the request for a new program.

Exception: If the household requests three months prior Medicaid coverage, staff should use an existing application. The file date of the application used should correspond with the three-month prior period to determine eligibility.

Once an application is filed, staff must take the following actions:

- enter the file date in the appropriate section on the application form, if received as a paper document;
- screen the application for expedited service eligibility for SNAP and TP 40;
- give the household Form H1800, Receipt for Application/Medicaid Report/Verification/Report of Change, on request;
- register the application when required; and
- schedule an interview appointment for the applicant when required as soon as possible.

Refer to special procedures in this section to determine the file date for TP 40, TP 40 Continuous Coverage and TP 45 Retroactive Coverage.

Related Policy

Application Requests and Submissions, A-113
Receipt of Application, A-121
Documentation Requirements, A-190
Eligibility for Three Months Prior Coverage, A-831.2

TP 40 Continuous Coverage

The file date is the date the advisor determines eligibility, if an application form is not used.

Related Policy

Continuous Medicaid Coverage, A-832

TP 45 Retroactive Coverage

The file date is the date the advisor is notified about the child's unpaid medical bills.

Related Policy

TP 45 Retroactive Coverage, A-833

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

The file date is the date a contracted facility accepts the application. If the application is not forwarded to HHSC within three business days, the file date is the date the HHSC office receives the application.

The file date is the date a person submits an application to any HHSC office. The application must be faxed or mailed to the correct office the same day it is returned.

The date the applicant clicks the Submit Application button in YourTexasBenefits.com is the file date for electronically filed applications. The file date is the next business day for applications received outside of business hours when HHSC is closed. This includes weekends and holidays.

A-122.1 Application Signature

Revision 25-3; Effective July 1, 2025

All Programs

The applicant must provide a signed application form before being certified. The signature can be captured anywhere on the same page the penalty of perjury statement is captured.

If the agency receives an application with no required signature and the application is not date-stamped, the application is considered invalid. Return the application with a letter and a pre-paid envelope explaining that the application must be signed before the agency can establish a file date.

If the agency accepts an application without a required signature and the application is date-stamped, the date the application is received is considered a valid file date. Send Form H1020, Request for Information or Action, along with the signature page requesting a signature. If the applicant fails to provide a signed application by the final due date, deny the application for failure to provide information.

Eligibility Support Vendor Action on Unsigned Applications

If the eligibility support vendor receives an unsigned application, the application is considered invalid. Within one business day, return the application to the household with a letter and a pre-paid envelope explaining that the application must be signed before a file date can be established.

The file date is the receipt date of the application if:

- the eligibility support vendor accepts an application without a signature; and
- it is not identified as missing a signature before data entry or the data entry date is more than one business day after the receipt date of the application.

The missing signature is treated as missing information.

Electronically Filed Applications

All Programs

Applications submitted online through YourTexasBenefits.com by the applicant or authorized representative (AR), are considered electronically signed.

Exception: Do not consider the application electronically signed when a non-applicant or non-AR completes and submits the online application for the household. In this situation, a pre-populated application is mailed to the household requesting a written signature from the applicant.

Signatures Elsewhere

Accept the applicant's signature on the first or last page of Form H1010 to establish a file date if the application meets all other application receipt requirements.

Note: If the applicant only provides a signed first or last page of Form H1010, do not require another signature.

TANF and Medical Programs

Applications Filed by Phone

An applicant, recipient, or AR may complete and sign an application by phone.

The applicant or AR may complete and sign an application over the phone by:

- providing their information over the phone to the customer care representative; and
- signing the application over the phone by stating their name and agreeing to a penalty of perjury statement read by the customer care representative. This information is being recorded for verification.

The customer care representative enters and submits the information provided by the applicant or AR through YourTexasBenefits.com.

Note: HHSC staff cannot accept telephonic signatures.

Applications signed and submitted over the phone by the applicant or AR are considered signed by phone except when:

- the applicant or AR declines to sign the application by phone; or
- a non-applicant or non-AR completes the application by phone for the household.

Correspondence is sent based on the following actions taken by the applicant or AR:

Action	Correspondence
Applicant or AR signs the application by phone	• Form H1031, Telephonic Signatures Cover Letter, notifies the household a telephonically signed Medicaid or TANF application or renewal was submitted. **Or**

Action	Correspondence
	• Form H1031A, SNAP Telephonic Signatures Cover Letter, notifies the household a telephonically signed SNAP application or renewal was submitted. It gives the household an opportunity to make and return corrections to HHSC.
Applicant or AR declines to sign the application by phone	• Form M5021A, Request for Missing Signature Cover Letter, notifies the person a signature is needed to complete the application process for TW medical programs; and • The unsigned Form H1010, Texas Works Application for Assistance - Your Texas Benefits, populated with information provided over the phone. **Or** • Form M5021C, Cover Letter for Missing Signature Letter, notifies the person a signature is needed to complete the application process for TW medical and MEPD programs; • The unsigned Form H1010, which is populated with information provided over the phone; or • The unsigned Form H1200, Application for Assistance - Your Texas Benefits, is populated with information provided over the phone.
Applicant or AR declines to sign the renewal by phone	• Form H1032, Cover Letter for Unsigned Your Texas Benefits Renewal Form, which notifies the person a signature is needed to complete the renewal process; and • Form H2020-YTB, Your Texas Benefits Renewal Form, the unsigned renewal populated with information provided over the phone.

Related Policy

Application Requests and Submissions, A-113
Authorized Representatives (AR), A-170

Signatures Elsewhere

All Programs

Accept the applicant's signature on the first or last page of Form H1010, Texas Works Application for Assistance - Your Texas Benefits, to establish a file date if the application meets all other application receipt requirements.

Note: If the applicant only provides a signed first or last page of Form H1010, do not require another signature.

SNAP

If SNAP is included in the combined application, Form H1031A, SNAP Telephonic Signatures Cover Letter, notifies the household a telephonically signed SNAP application or renewal was submitted and gives the household an opportunity to make and return corrections to HHSC.

Medical Programs

If an applicant signs and returns only Form H1010-MR, MAGI Renewal Addendum, with no corresponding application, the application is considered invalid. Attempt to contact the applicant by phone and advise them to file an application. No action is taken on Form H1010-MR without a corresponding application.

If the applicant returns a signed application without Form H1010-MR, consider the application incomplete. Send Form H1020, Request for Information or Action, with Form H1010-MR requesting the necessary information to make a determination based on Modified Adjusted Gross Income (MAGI) rules. If the applicant fails to provide a completed Form H1010-MR by the final due date, deny the request for failure to provide information.

Related Policy

Application Requests and Submissions, A-113
Receipt of Application, A-121

A-122.2 Scheduling Appointments

Revision 26-2; Effective April 1, 2026

SNAP and TANF

An interview is required at application and redetermination. Complete an interview even if the application only has the applicant's name, address, and signature. Attempt to interview the applicant as a lobby walk-in or by making a cold call. Mail the applicant Form H1830, Application, Review, Expiration, Appointment Notice if the cold call is unsuccessful. It provides the applicant information on how to call the agency for a flexible appointment interview.

Medical Programs

An interview is not required. Process the application unless the applicant requests an interview.

Process the application without an interview if an interview is requested by the applicant and they fail to keep it. Do not deny the EDG for a missed appointment or send Form H1020-MA-FA, Request for Information or Action-Missed Appointment-Flexible Appointment.

Exceptions:

- If the applicant was previously denied for failure to provide Form H1024, Subject: Self-Declaration Notice for missing an appointment about HCO or Texas Health Steps noncompliance, schedule a phone interview and deliver the HCO. Remind the applicant about the importance of the Texas Health Steps checkup at that time.
- Staff conduct an interview for an initial application or redetermination when HHSC receives conflicting information about household composition or income that affects eligibility and the information cannot be verified through other means, such as an associated EDG.

Related Policy

Interviews, A-131
Explanation of Benefits, A-1531.4
Compliance Requirements, A-1531.5

A-122.3 Registering an Application

Revision 22-3; Effective July 1, 2022

All Programs

Perform Application Registration (App Reg) within one workday after the file date when application registration is required.

To prevent overpayments or incorrectly providing benefits, take the following action before registering an application:

- screen each application filed; and
- associate the old case number in File Clearance when appropriate.

Perform inquiry on all household members applying for benefits listed on the application for assistance. Use Social Security numbers (SSNs), case name search and available case or EDG numbers to determine case status.

If inquiry shows …	then …
no record,	follow established local office procedures for processing applications.
an individual record,	check case and EDG status (active or denied). **If the case is active**, determine if the person is currently active on another case in the same program. If the person is: • not currently active in the same program, register the application. • entitled to dual SNAP participation as a resident of a shelter for battered persons, follow procedures in B454.1, Duplicate Participation Procedures. • currently active in the same program and is not entitled to dual benefits, take appropriate action to prevent duplicate participation. Process an overpayment, if applicable. **If the case is denied**, associate the old case number in File Clearance after determining that this is the same household.

If inquiry shows …	then …
a SNAP-Combined Application Project (CAP) case record,	check for CBS status in TIERS inquiry. SNAP-CAP will be listed as FS-SNAP under Current EDG Affiliations in case inquiry results and under Current Eligibility in individual inquiry results. Follow established local office procedures applicable to the specific case situation.

A-123 Withdrawal of an Application

Revision 15-4; Effective October 1, 2015

All Programs

The individual may voluntarily withdraw an application any time before certification.

SNAP

If someone other than the head of household, spouse, a responsible household member, or an AR requests a withdrawal, staff should contact the household to confirm the withdrawal.

Related Policy

The Texas Works Message, A-1527

A-124 Processing Presumptive Eligibility Applications

Revision 15-3; Effective July 1, 2015

TA 66, TA 74, TA 75, TA 76, TA 83, TA 86 and TP 42

Presumptive eligibility (PE) provides short-term medical coverage to pregnant women, MBCC applicants, children under age 19, parents and caretaker relatives of dependent children under age 19, and former foster care children. PE provides full fee-for-service Medicaid with the exception of pregnant women. Pregnant women receive ambulatory prenatal care only.

Qualified hospitals (QHs) determine PE for all groups except MBCC.

Qualified entities (QEs) determine PE for pregnant women and MBCC applicants. For MBCC applicants, only QEs that are also Texas Department of State Health Services (DSHS) Breast and Cervical Cancer Services contractors may make MBCC PE determinations, following the process outlined in X100, Application Processing.

A-124.1 Eligible Groups

Revision 15-3; Effective July 1, 2015

The following groups can receive presumptive eligibility coverage:

- Children:
  - MA-Children Under 1 Presumptive — TA 74
  - MA-Children 1–5 Presumptive — TA 75
  - MA-Children 6–18 Presumptive — TA 76
- Former Foster Care Children (MA-FFCC Presumptive — TA 83)
- Pregnant Women (MA-Pregnant Women Presumptive — TP 42)
- Parents and Other Caretaker Relatives (MA-Parents and Caretaker Relatives Presumptive — TA 86)

A-124.2 File Clearance

Revision 15-3; Effective July 1, 2015

TIERS performs automated file clearance for each individual determined presumptively eligible if the individual has a 100 percent match in TIERS or if there is no match for the individual in TIERS. For individuals for whom TIERS cannot perform automated file clearance, TIERS triggers an alert to create a TLM task for staff to manually do file clearance for the individual. TIERS routes manual file clearance tasks to the Out-stationed Worker Program (OWP) queue for assignment and processing.

A-124.3 Task List Manager

Revision 15-3; Effective July 1, 2015

When TIERS cannot automatically perform file clearance for an individual whom a QH/QE has determined to be presumptively eligible, an OWP advisor needs to take action. TIERS creates the task "Process a File Clearance Failure for Presumptive Eligibility" and sends it to an OWP advisor based on the applicant's ZIP code.

To complete the task, the advisor:

1. Selects the Work icon.
2. Selects the individual who needs file clearance from the **Presumptive Eligibility Individual — Summary page**.
3. Matches the PE individual to the TIERS individual on the **PE File Clearance — Results page**.
4. Selects **Auto Process PE** on the **File Clearance — Results page** to complete the task once the advisor has performed file clearance for all individuals on the case.

The advisor can also manually clear the task. When an advisor searches for an application on the **Self Service Application Search** page, the **SS Application Search Results section** displays a **Determine PE** link if a PE individual on the case requires manual file clearance. TIERS displays the **Presumptive Eligibility Individual — Summary page** when the advisor clicks the link.

Once the advisor completes file clearance, TIERS notifies TLM to close the QH/QE PE task.

A-124.4 Application Processing

Revision 15-3; Effective July 1, 2015

The TLM routes applications for regular Medicaid from individuals whom a QH/QE has determined to be presumptively eligible for Medicaid to an OWP advisor for processing. If the QH has an OWP advisor, the TLM assigns the application to that advisor for processing. If the QH does not have an OWP advisor or a QE submits the application, the TLM routes the application to the regional OWP queue.

Process the applications using current policy and application processing time frames. See B112, Deadlines. If both a PE task for file clearance and a regular Medicaid application exist for the same person, clear the PE task first.

A-124.5 Verifications

Revision 15-3; Effective July 1, 2015

Use standard verification requirements when processing an application for regular Medicaid from an individual determined presumptively eligible. See C900, Verification and Documentation.

Related Policy

Verifications, C1113.4

A-124.6 Medical Effective Date

Revision 15-4; Effective October 1, 2015

The medical effective date for PE is the date that the QH or QE determines the individual is presumptively eligible for Medicaid.

Note: An individual is not eligible for PE coverage if the individual is currently certified for Medicaid, CHIP or CHIP perinatal.

If the individual does not apply for regular Medicaid, PE coverage ends the last day of the month after the month of the PE determination (see scenario 1 below).

If the individual submits Form H1205, Texas Streamlined Application, or Form H1010, Texas Works Application for Assistance — Your Texas Benefits, HHSC determines whether the individual is eligible for regular Medicaid. If the person is not eligible for regular Medicaid, the individual's PE coverage ends the date that HHSC determines the individual is ineligible (see scenario 2 below). If the person is eligible for regular Medicaid, the person’s PE coverage ends when HHSC makes the Medicaid eligibility determination, following cutoff rules.

If an individual is Medicaid-eligible during the application month, the individual receives Medicaid from the first of that month through the PE MED. Regular Medicaid coverage for the ongoing period starts once the PE period ends (see scenarios 3 and 4 below). **Exception**: Since PE for pregnant women provides only limited prenatal services, ongoing Medicaid coverage overlays the PE coverage (see scenario 5 below).

Examples:

PE Scenarios

1. Individual does not apply for regular Medicaid	A child is determined eligible for MA-Children 6–18 Presumptive on February 2. Her mother does not submit an application for regular Medicaid. The child's PE coverage ends on March 31.
2. Individual is ineligible for regular Medicaid	A child is determined eligible for MA-Children Under 1 Presumptive on April 4. Her father submits an application for regular Medicaid on the same date. HHSC determines on April 20 that the child is not eligible for regular Medicaid. Her PE coverage ends on April 20.
3. Individual is eligible for regular Medicaid (HHSC makes eligibility determination before cutoff)	A child is determined eligible for MA-Children 1–5 Presumptive on March 6. His mother submits an application for regular Medicaid on the same date. HHSC determines on March 15 (before cutoff) that the child is eligible for regular Medicaid. His PE coverage ends March 31. He is certified for regular Medicaid effective March 1 to March 5 and April 1 through ongoing.
4. Individual is eligible for regular Medicaid (HHSC makes eligibility determination after cutoff)	A former foster care child is determined eligible for MA-FFCC Presumptive on May 9. He submits an application for regular Medicaid on the same date. HHSC determines on May 22 (after cutoff) that the individual is eligible for regular Medicaid. His PE coverage ends June 30. He is certified for regular Medicaid effective May 1 to May 8 and July 1 through ongoing.
5. Pregnant woman is eligible for regular Medicaid	A woman is determined eligible for MA-Pregnant Women Presumptive on June 4. She submits an application for regular Medicaid on the same date. HHSC determines on June 10 that the woman is eligible for regular Medicaid. Her PE coverage ends on June 30. Regular Medicaid overlays her PE coverage with an effective date of June 1.

A-124.7 Periods of Presumptive Eligibility

Revision 15-3; Effective July 1, 2015

Pregnant women are allowed one PE period per pregnancy.

For all other PE groups, an individual is allowed no more than one period of PE per two calendar years. **Example**: An individual receives PE for children ages 6–18 in June 2015. He cannot receive another period of PE until January 2017.

A-124.8 Fair Hearings

Revision 15-3; Effective July 1, 2015

Appeals and fair hearings do not apply to PE.

A-124.9 Questions About the Presumptive Eligibility Process

Revision 20-4; Effective October 1, 2020

Refer hospitals and entities that are interested in becoming qualified to make PE decisions to the PE website.

Refer a person with questions about their PE coverage dates to the QH/QE that made the PE determination. For questions about services covered by Medicaid, tell the person to call the Medicaid help line at 800-335-8957.

A-124.10 Presumptive Eligibility Forms

Revision 15-3; Effective July 1, 2015

Qualified hospital/qualified entity staff use the following forms in the presumptive eligibility process:

- **Form H1265, Presumptive Eligibility (PE) Worksheet** — Completed by the QH/QE and used to determine if an applicant is presumptively eligible.
- **Form H1266, Short-term Medicaid Notice: Approved** — Completed by the QH/QE and given to an individual determined presumptively eligible. This form notifies the individual about PE coverage and lists the eligibility start and end dates. If an individual takes this form to a local eligibility determination office and requests a temporary Medicaid identification card, give the person Form H1027-A, Medicaid Eligibility Verification.
- **Form H1267, Short-term Medicaid Notice: Not Approved** — Completed by the QH/QE and given to an individual determined ineligible for PE coverage. This form explains the reason for ineligibility and how to apply for regular Medicaid.

Related Policy

Qualified Hospital/Qualified Entity Policy and Procedures for Presumptive Eligibility Determinations, C1113

A-125 TP 45 Provider Referral Process

Revision 25-1; Effective Jan. 1, 2025

TP 45

Customer Care Center (CCC) Data Integrity (DI) uses the Provider Referral Process when a hospital, birthing center or Federally Qualified Health Center (FQHC) submits a referral directly to DI for a newborn whose mother is Medicaid eligible. The provider does not submit a claim for payment to the claims administrator for the child at this time.

DI verifies the mother's Medicaid coverage, which can be retroactive, and creates a TP 45 EDG for the newborn.

Coverage for the child begins on the child's date of birth (DOB). The last month of coverage is the last day of the month that the child turns one, except in the following situations:

- The hospital notifies DI through the Texas Electronic Registration (TER) system or Form 7484, Hospital Report for Newborn Child or Children, that the child's mother relinquished her parental rights.
  - If TER or Form 7484 indicates a relinquishment, but the new caretaker's information is incomplete or not provided, DI provides newborn Medicaid coverage from the child's DOB through the end of the month the child is relinquished.
  - If TER or Form 7484 indicates a relinquishment, and the new caretaker's name and address are provided, DI completes two case actions. The first action is to process an open and close newborn Medicaid EDG with the birth mother as the case name. The coverage begins with the child's DOB and continues through the end of the month the child was relinquished. The second action is to open a newborn Medicaid case or EDG with the new caretaker as the case name. The coverage begins the first of the month after the original newborn Medicaid coverage ended and continues through the month of the child's first birthday.
- The child's mother received TP 42 Pregnant Women Presumptive coverage at the time of the child's birth, and the mother's application for regular Medicaid coverage is denied. DI certifies the child through the birth month.

The computer generates and sends the following documents for each EDG:

- Notice of the newborn's individual number to the referring provider and other providers, if identified on the provider's referral;
- Your Texas Benefits Medicaid card to the newborn's mother; and
- Notice informing the newborn's mother or caretaker:
  - that the child is eligible to receive medical coverage through the month of their first birthday while they remain a Texas resident and to report any changes concerning these eligibility requirements;
  - to report any incorrect information on Form H1027-A, Medicaid Eligibility Verification;
  - to report if the newborn's siblings receive TANF; and
  - if the mother's Medicaid end date changes because the child was not born in the anticipated month.

A-125.1 Advisor Action in Provider Referral Process

Revision 15-4; Effective October 1, 2015

TP 45

A task is created when a TP 45 EDG is established and the TIERS case contains an active SNAP or TANF EDG. The advisor must take the following actions once the advisor claims the newborn alert task.

If ...	then ...
the newborn is a mandatory member of a TANF-certified group or SNAP household,	process to add the child to the TANF or SNAP EDG as explained in B641.1, Adding Newborns to the Case.
the child is **not** a mandatory member of a TANF-certified group, but the child's mother or caretaker provides additional information about the child (name, SSN, etc.),	add these changes to the TP 45 EDG.
the newborn's siblings are included in the MAGI household composition for a TP 43, 44, or 48,	take no action on the siblings' EDG until additional information is requested for the siblings. At that point, request verification of tax status and relationship for the newborn. If the mother provides verification of relationship for the newborn, add the newborn to the siblings' budget groups.
the child becomes ineligible for TP 45 before the child's first birthday,	deny TP 45 for the child, using the appropriate denial code.

A-125.2 Suspended Claim Process

Revision 15-4; Effective October 1, 2015

TP 45

The Medicaid provider sends a claim for a newborn child with the child's mother's claim to the claims administrator. If the claims administrator cannot find the child on HHSC's eligibility files, the claims administrator suspends the child's claim and sends an exception notice to State Office Data Integrity (SODI). SODI checks the child's mother's Medicaid eligibility. If the mother received Medicaid at the time of the child's birth, including a retroactive determination, SODI follows procedures in the Provider Referral Process to provide Medicaid coverage for the child.

A-125.3 Mandated TIERS Inquiry

Revision 15-4; Effective October 1, 2015

TP 45

Field staff must perform TIERS inquiry before providing coverage for a newborn when there is no evidence of SODI TP 45. Staff should inquire by the newborn's mother's individual number and look for a process date that is after the child's DOB.

A-126 Processing Children’s Insurance Applications

Revision 15-4; Effective October 1, 2015

See A-113, Application Requests and Submissions, for how to apply for Medical programs for children.

A-126.1 Front Desk Process

Revision 15-4; Effective October 1, 2015

CHIP and TP 43, TP 44 and TP 48

When individuals come to a local eligibility office to inquire about health insurance for their child(ren), the front desk clerk must:

- explain the ways to submit an application as outlined in A-113, Application Requests and Submissions; and
- explain that the Medicaid application process provides that if a child is found ineligible for Medicaid based on income, HHSC will test the child for CHIP and, if eligible, the Enrollment Broker will send an enrollment packet to the household.

A-126.2 Inquiry

Revision 15-4; Effective October 1, 2015

CHIP and TP 43, TP 44 and TP 48

Before certifying a child for any type of Medicaid program, advisors must perform an inquiry to determine whether the child applying for Medicaid is already enrolled or pending enrollment in Medicaid, CHIP, or CHIP perinatal.

A-126.3 Advisor Action for Determining Eligibility for Children

Revision 16-2; Effective April 1, 2016

CHIP and TP 43, TP 44 and TP 48

When taking action on an application, the following procedures must be applied:

If ...	then ...
The child applying is not active in CHIP or pending CHIP enrollment,	test for Medicaid eligibility. Follow the policy for assigning the MED*.
The child applying is active in CHIP and the CHIP end date is the application month or the following month,	test for Medicaid eligibility. If eligible, and it is:

If ...	then ...
	• before cutoff, begin Medicaid coverage the first day of the next month. • after cutoff, begin Medicaid coverage the first day of the month following the next month.
The child applying is active in CHIP and the CHIP end date is later than the month following the application month,	test for Medicaid eligibility. If eligible, and processing is: • before cutoff, begin Medicaid coverage the first day of the next month. • after cutoff, begin Medicaid coverage the first day of the month following the next month.
The child applying is pending CHIP enrollment with a start date the first day of the next month,	test for Medicaid eligibility for the three months prior, if the application indicates unpaid medical bills. Test for ongoing Medicaid eligibility. If eligible, and it is: • before cutoff, follow the policy for assigning the MED. • after cutoff, begin Medicaid coverage the first day of the month following the next month. Provide open/close coverage for the application month and/or prior months, if applicable.
The child applying is pending CHIP enrollment with a start date later than the first day of the next month,	test for Medicaid eligibility for the three months prior, if the application indicates unpaid medical bills. Test for ongoing Medicaid eligibility. Follow the policy for assigning the MED.
The child is active in CHIP, the application indicates she is pregnant, and the CHIP end date is in the application month,	test for Medicaid eligibility. If eligible, begin Medicaid coverage the first day of the month following the CHIP end date.
The child is active in CHIP, the application indicates she is pregnant, and the CHIP end date is in the month following the application month or later,	test for Medicaid eligibility. If eligible, and it is: • before cutoff, begin Medicaid coverage the first day of the next month. • after cutoff, begin Medicaid coverage the first day of the month following the next month.
One child in the family applying is active in CHIP and another is not,	test for Medicaid eligibility. If eligible, follow the applicable guidelines given in the preceding scenarios, for each child.

* See A-820, Regular Medicaid Coverage, to apply the MED.

After determining a child is ineligible for Medicaid, TIERS will test eligibility for CHIP.

When the head of household does not provide their date of birth (DOB) and/or Social Security number (SSN), the following steps are taken to obtain the information:

- Call the household to try to obtain the correct DOB and/or SSN. Let the household know this information is voluntary and is not required to make an eligibility determination for the child; however, it will help expedite the process.
- If unable to obtain the DOB and/or SSN by telephone, continue to process the child's application for Medicaid.
- Select a random DOB for the caretaker/second parent, with a year between 1965 and 1975. Using randomly selected DOBs reduces or eliminates the problem of duplicate individual numbers.
- The SSN field is left blank if the correct number is not available.
- Staff ensure that all other demographic information is correct and include the individual's middle name, when available.

A-126.3.1 Neonatal Intensive Care Unit (NICU) Newborn Process

Revision 15-4; Effective October 1, 2015

CHIP Perinatal, TP 36, TP 43 and TP 45

Income Above the Limit for Medicaid for Pregnant Women (TP 40)

When a CHIP perinatal mother whose household income is above the income limit for TP 40 applies for Medicaid for her newborn and HHSC hospital-based staff have information from the applicant or the hospital that the newborn is medically fragile and that the newborn is admitted into the NICU, HHSC hospital-based staff must certify the newborn using the following process:

- Upon receipt of an application for a Medicaid NICU newborn, HHSC hospital-based staff must perform inquiry to determine if the mother is on CHIP perinatal or whether the newborn has been assigned a TIERS individual identification (ID) number and is active on Medicaid.
- If the newborn is not active on Medicaid, staff must deny the CHIP perinatal and certify the eligible newborn for TP 43, if eligible, following existing policy.
- If not eligible, test the newborn for TP 56 and do not deny the newborn's CHIP perinatal coverage.
- If eligible, the newborn may receive TP 56 and CHIP perinatal coverage.

Income at or Below the Limit for Medicaid for Pregnant Women (TP 40)

When HHSC hospital-based staff have information from the applicant or the hospital that a newborn born to a CHIP perinatal mother whose household income is at or below the income limit for TP 40 is medically fragile and that the newborn is admitted into the NICU, HHSC hospital-based staff must certify the eligible mother for Emergency Medicaid and the newborn for TP 45, effective on the newborn's date of birth. The CHIP perinatal mother must submit Form H3038-P, CHIP Perinatal — Emergency Medical Services Certification, to the hospital. HHSC hospital-based staff must process Form H3038-P.

Upon receipt of Form H3038-P, HHSC hospital-based staff must:

- perform inquiry on the Newborn Perinatal Match Interface (Interfaces – TIERS Left Navigation) to verify the CHIP perinatal household's FPIL;
- use the date Form H3038-P is provided as the file date for both the Emergency Medicaid and Medicaid for the newborn child;
- certify the CHIP perinatal mother for Emergency Medicaid and deny the CHIP perinatal Eligibility Determination Group (EDG); and
- certify the eligible newborn for TP 45, effective on the newborn's date of birth.

Related Policy

Adding a New Child, D1433.1

A-126.4 CHIP Good Cause

Revision 15-4; Effective October 1, 2015

CHIP good cause is explained in D-1723.6, Good Cause Exemptions for Children Subject to the 90-day Waiting Period.

A-126.4.1 Claiming Good Cause

Revision 15-4; Effective October 1, 2015

CHIP good cause is explained in D-1723.6, Good Cause Exemptions for Children Subject to the 90-day Waiting Period.

A-127 Prior Medicaid Coverage

Revision 15-4; Effective October 1, 2015

Children's Medicaid and TP 33, TP 34 and TP 35

Staff use any valid application or renewal form to determine three months prior coverage for Children's Medicaid. Do not require Form H1113, Application for Prior Medicaid Coverage, if the family provides enough information to determine eligibility for prior months. If the family does not provide enough information and cannot be reached by telephone, staff sends Form H1113 with Form H1020, Request for Information or Action, to request verification. **Note**: Three months prior coverage does not apply to CHIP. See D-1723.5, Coverage Start Dates, to determine when CHIP coverage begins.

Staff must not delay certification of ongoing eligibility to determine if any child is eligible for prior coverage.

Related Policy

Medicaid Coverage for the Months Prior to the Month of Application, A-830

A-128 Processing Applications for Pregnant Women

Revision 15-4; Effective October 1, 2015

CHIP Perinatal, TP 40 and TP 36

A pregnant woman may apply for health care coverage using applications and ways to submit an application explained in A-113, Application Requests and Submissions.

When a pregnant woman applies for health care coverage, she will first be tested for TP 40 coverage. If ineligible for TP 40, TIERS will determine whether the woman is eligible for CHIP or CHIP perinatal.

CHIP perinatal coverage provides services to unborn children of pregnant women, regardless of age, who are at or below the program income limit and are ineligible for:

- Medicaid because of immigration status or income; or
- CHIP because of age or immigration status.

CHIP perinatal households are exempt from the:

- 90-day waiting period;
- cost-sharing (enrollment fees and co-payments); and
- six-month income check.

A-128.1 Inquiry for Pregnant Women

Revision 15-4; Effective October 1, 2015

CHIP Perinatal, TP 40 and TP 36

Before certifying a pregnant woman for any type of health care coverage, advisors must perform inquiry to determine whether the pregnant woman is already certified for Medicaid or enrolled or pending enrollment in CHIP or CHIP perinatal.

Searching by the woman's last name and date of birth may increase the possibility for a match.

A-128.2 Staff Action for Determining Eligibility for Pregnant Women

Revision 21-2; Effective April 1, 2021

TA 85 (CHIP-P), TP 40 and TP 36

When taking action on an application, apply the following procedures.

If ...	then ...
the woman is active in CHIP perinatal and the application indicates she is due in the application month,	test for Medicaid eligibility.* If eligible, and she is: • not a U.S. citizen or alien with acceptable status, certify the woman for Emergency Medicaid coverage for the birth and certify the newborn for TP 45 Medicaid coverage.
the woman is active in CHIP perinatal and the application indicates she is due in the month following the application month or later,	test for Medicaid eligibility.* If eligible, and it is: • before cutoff, begin Medicaid coverage the first day of the next month. • after cutoff, begin Medicaid coverage the first day of the month following the next month.

* When a woman enrolled in CHIP perinatal submits a new application, they must be tested for Medicaid coverage. When processing a change for a woman certified for CHIP perinatal, TIERS will automatically test for Medicaid eligibility. A new application is not required.

A-128.3 CHIP Perinatal Application Process

Revision 21-2; Effective April 1, 2021

TA 85 (CHIP-P), TP 36 and TP 45

CHIP perinatal (TA 85) covers labor with delivery charges for households with income above the income limit for Medicaid for Pregnant Women (TP40), but not for households that qualify for Emergency Medicaid coverage (women who do not meet citizenship requirements, and whose household income is at or below the income limit for TP40). These Medicaid-eligible households must submit Form H3038-P, CHIP

Perinatal — Emergency Medical Services Certification, to apply for Emergency Medicaid to pay for these charges. A woman certified for TA 85 with household income above the TP40 income limit cannot be certified for Emergency Medicaid to cover the labor with delivery charges.

A child born to a CHIP perinatal mother whose household income is at or below the income limit for TP40 and who receives Emergency Medicaid to cover labor with delivery charges is enrolled in Medicaid instead of CHIP perinatal.

Thirty days before the expected due date, TIERS generates and sends Form H3038-P with Form H1061, Birth Outcome Letter, to the household. If the household has not reported the child's birth by 30 days after the expected due date, TIERS sends a Form H1062, Birth Outcome Reminder Letter, and a second Form H3038-P with instructions for getting Form H3038-P completed and signed by the medical practitioner, along with a self-addressed postage-paid envelope. The household must return Form H3038-P to HHSC.

Upon receipt of Form H3038-P:

- the form is linked to the mother's case; and
- a task is created for Customer Care Center (CCC) staff to certify the mother for Emergency Medicaid and the newborn for TP 45.

Staff must not certify the mother for Emergency Medicaid or the newborn for TP 45 if the household has not returned Form H3038-P within 60 days from the date of the expected pregnancy due date. Reopen three-month prior applications for people who return Form H3038-P after 60 days from the expected pregnancy due date.

Note: For newborns admitted to the Neonatal Intensive Care Unit (NICU), process both the Emergency Medicaid coverage for the mother and the TP 45 for the newborn.

CCC Staff Process

CCC is assigned a task to process Form H3038-P. Staff must:

- determine whether mother and newborn are already active on Medicaid;
- if mother and newborn are not active on Medicaid, use all TP 40 eligibility policies and procedures to determine Emergency Medicaid eligibility, except when verifying income and citizenship/alien status;
- use the verified income provided to determine CHIP perinatal eligibility to determine Emergency Medicaid eligibility. **Note:** TIERS will not run financial rules when certifying a recipient for Emergency Medicaid and will instead use the verified income used to determine the woman's CHIP Perinatal eligibility;
- verify all non-financial eligibility points prior to certification using:
  - identity verification sources; and
  - residence verification sources;
- use the date Form H3038-P is received as the file date for the Emergency Medicaid and TP 45; and
- process Form H3038-P by the 45th date after the file date.

The file date for the TP 45 is usually the date Form H3038-P is received if it includes the newborn's information. Birth outcome information can also be received via the newborn interface or from the person by phone or in writing. When birth outcome information is received after Form H3038-P has already been submitted to the HHSC, a second task is assigned to CCC to process TP 45 coverage for the newborn.

When CCC staff receive a task that includes Form H3038-P dated more than 60 days after the pregnancy due date, CCC must stamp "Received (Date) CCC" on Form H3038-P, to indicate the form was provided after the 60 days from the pregnancy due date. CCC staff must return Form H3038-P along with an application and a letter informing the person that they must apply for Medicaid. The person is instructed to complete the application and return it to the nearest HHSC office or appropriate out-stationed worker, if an out-stationed worker is housed at the hospital where the delivery took place.

Out-Stationed and HHSC Eligibility Office Staff Process

The chart below explains procedures staff must follow to determine appropriate action.

If an applicant…	then staff must:
provides Form H3038-P **only**, and was active on CHIP perinatal at the time of the delivery,	fax Form H3038-P to **877-447-2839**.
provides an application requesting Medicaid **only**, provides Form H3038-P, and was active on CHIP perinatal at the time of delivery,	follow policy for receipt of duplicate or identical application and fax Form H3038-P to 877-447-2839.
provides an application requesting Medicaid and other benefits (SNAP, Medicaid, TANF), provides Form H3038-P, and was active on CHIP perinatal at the time of delivery,	• certify the TP 36 coverage when determining eligibility for the other requested programs (including TP 45) following existing policy, if eligible; or • fax only Form H3038-P to **877-447-2839** if the mother is ineligible for Emergency Medicaid based on the current information.

If an applicant…	then staff must:
provides an application and Form H3038-P stamped with "Received (Date) CCC,"	process the request for Medicaid following normal application procedures.
was not active on CHIP perinatal at the time of delivery,	process the Emergency Medicaid request per existing policy and certify TP 45 if appropriate.

Notes:

- Fax the bar-coded Form H3038-P to 877-447-2839. If Form H3038-P is not bar-coded, write the mother's case and CHIP perinatal EDG number on the top of the form.
- If the applicant requests the fax number for Form H3038-P, instruct the applicant to fax the form to **877-447-2839**.

Related Policy

Receipt of Duplicate Application, A-121.2
Receipt of Identical Application, A-121.3
Neonatal Intensive Care Unit (NICU) Process, A-126.3.1
Verification Sources, A-621
Verification Sources, A-761
Reopening Three Months Prior Applications, A-831.2.1
Deadlines, B-112

A-129 Data Broker Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Staff must request Data Broker reports as required in C-820, Data Broker.

Related Policy

Permissible Purpose, C-824

A-130, Interview Procedures

Body

A-131 Interviews

Revision 26-2; Effective April 1, 2026

TANF and SNAP

Conduct an interview at application and redetermination with the applicant or the applicant's spouse if the spouse is a member of the household to determine eligibility.

Exceptions:

- A household may designate an authorized representative (AR), who must also sign the application.
- For SNAP, another responsible household member may also be interviewed.
- For TSAP redeterminations, no interview is required unless the household requests an interview, the case contains earned income, or it appears the household is going to be denied.

Note: The spouse, or other responsible household member for a SNAP interview, does not have to sign the application to be interviewed. Staff must not exempt the household from any program or verification requirements due to interviewing an AR or conducting a phone interview.

Medical Programs

Interviews are not required for medical programs but can be requested by the applicant or recipient. Document how the person's identity was verified if an interview is conducted for a non-interview required program.

Related Policy

Authorized Representatives, A-170
SNAP Programs, B-474.1.1
Texas Simplified Application Project (TSAP) for SNAP Food Benefits, B-477

A-131.1 Home Visits

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must provide notice to the household before making any home visit. Application and redetermination interviews must be scheduled in writing. Notification of other home visits may be:

- verbal,
- given or mailed to the individual, or
- by telephone contact with a responsible household member.

The notification should include the time (at least whether morning or afternoon) and date of the visit. Advisors should route the notification for imaging to add to the electronic case record or document the specific information in TIERS Case Comments. If regions have specialized staff that conduct home visits, the documentation may be maintained in a separate location as long as it is accessible if needed.

Home visits to collateral sources do not have to be scheduled in advance.

No one should be denied for refusing to agree to a home visit unless there is no other sufficient and reliable verification available.

Related Policy

Advisor Responsibility for Verifying Information, C932

A-131.2 Requirement to Provide Interpreter or Translation Service

Revision 15-4; Effective October 1, 2015

All Programs

HHSC is required to provide interpreter and translation (written or verbal) services to applicants and recipients with Limited English Proficiency (LEP). Consider an individual with LEP even if they do not request an interpreter on the application if the individual indicates they would like to speak a language other than English during the interview. HHSC is also required to provide an effective method to communicate with applicants and recipients who indicate they are deaf or hearing impaired. Applicants and recipients may indicate on an application or during an interview that they need interpreter services.

A-131.2.1 Availability of Interpreters and Translation Services

Revision 23-3; Effective July 1, 2023

All Programs

Local offices must set up procedures to ensure interpreters and translators are available for applicants or recipients who indicate needing such services on an application.

To meet the requirement for applicants and recipients who indicate they are Limited English Proficiency (LEP), offices can use:

- Bilingual advisors – when it is reasonably possible to do so, schedule LEP applicant or recipient interviews with bilingual advisors.
- Bilingual clerical staff – use bilingual clerical staff as interpreters whenever possible.
- Local community interpreter providers.

Use the following methods for interpretation only after exhausting all local and regional resources:

- Language Line Services – This service is available to all regions. Staff can use the service by calling the primary vendor at 844-403-1611 or the secondary vendor at 866-975-3097 and using their 11-digit employee identification number.
- • Applicants or recipients may provide their own interpreter if they wish to do so. **Note:** A minor, 15 or older, can act as an interpreter at the person's request and when the minor accompanies the person to the interview. Do not use a minor under 15 as an interpreter.

To meet this requirement for applicants and recipients who indicate they are deaf or hearing impaired, offices can:

- Schedule a phone interview if the applicant indicates the contact phone on the application is a TDD/TTY line unless the applicant requests a face-to-face interview.
  Note: Relay Texas can be reached at these numbers:
  - 7-1-1, 800-RELAYTX (800-735-2989), Spanish to English (Spanish speaking callers to English speaking HHSC staff) at 888-777-5861; and
  - and Spanish to Spanish at 800-662-4954.
- If unable to reach the applicant by phone, schedule a face-to-face interview and arrange for interpreter services at the interview location.

Note: In situations where an interpreter services vendor is not available, the use of handwritten notes with the hearing-impaired person is allowed. The notes must be an effective and acceptable means of communication for the person.

A-131.2.2 Availability of Translated Written Material

Revision 15-4; Effective October 1, 2015

All Programs

Staff must inform applicants/recipients about the availability of translation (written or verbal) services regarding written materials HHSC sends to them by following the two processes below, when applicable.

When staff verbally communicate with LEP applicants/recipients at application, redetermination (including desk reviews) and change actions, staff must ensure that applicants/recipients understand the eligibility action (Form H1020, Request for Information or Action, and Form TF0001, Notice of Case Action) being taken and the requirements for the application process (including any missing information being requested). Providing a verbal explanation to all LEP applicants/recipients in their preferred language regarding the eligibility action being taken and/or missing information being requested meets this requirement.

Note: This requirement is not applicable for desk reviews and change actions when staff process the case action without talking with the applicants/recipients.

The Vietnamese Translation Interpreter Form is automatically attached to applicable eligibility notices when clients select Vietnamese as their primary household language.

A-131.3 Interview Requirements

Revision 26-2; Effective April 1, 2026

All Programs

During the interview, staff must:

- protect the household's confidentiality and conduct the interview as a confidential discussion of household circumstances;
- review the application and resolve unclear and incomplete information with the household;
- advise the household of their rights and responsibilities, including the right to appeal, voter registration, work requirements and other general reminders;
- advise the household of the application processing time frames;
- advise the household of their responsibility to report changes; and
- ensure that the address in the eligibility determination system reflects the household's current address.

Staff must take the following actions and provide the following referrals and information during the interview:

- Verify that the household agrees the information is complete and correct on the application form and in the case documentation for household composition, income, and expenses.
- Verify that the income and expense information from past periods including self-employment, accurately reflect the amounts that can be anticipated for future income and expenses. If the information is inaccurate, determine why it is inaccurate.
- Determine if households with questionable or negative management can explain how the household's bills are paid.
- Determine if households with other discrepancies in information that could affect eligibility can provide information to resolve those discrepancies.
- Determine if households who have not provided all verification requested on Form H1020, Request for Information or Action, have a reason beyond their control that prevents the household from providing verifications. If a collateral source is designated, accept the household's statement or use other forms of verification for the missing verifications.
- Determine if income verification may be calculated based on year-to-date information from other paychecks provided by the household when income verification is missing for a particular pay period(s), rather than requesting it on Form H1020.
- Refer the household to other state or local resources for types of assistance the household requested on the application form, such as childcare, child support, utilities, or rent, that are provided by other agencies.

TANF

Determine if:

- any adult household member received TANF cash assistance from another state since October 1999;
- any member of the household was disqualified in another state for a felony or drug conviction;
- any member of the household was disqualified from participating in TANF for an intentional program violation (IPV) in another state; and
- applicants must provide information on parent(s) living outside of the home to meet child and medical support requirements, or if applicants meet a good cause exemption.

SNAP

- Determine if households qualifying for the standard medical expense want to claim actual expenses.
- Determine if the household wants to prorate an expense or income.
- Determine if any household member claims an exemption to Employment and Training (E&T) work requirements.
- Provide reminders. Include the household's change reporting requirement, for E&T requirements, able-bodied adult without dependents (ABAWD) time limit policy if there is an ABAWD in the household, and how the household can get and use SNAP benefits issued via EBT.
- Determine if an ABAWD received any countable months of benefits in another state.
- Determine if any member of the household was disqualified from participating in SNAP for an IPV or a felony drug conviction in another state. **Note**: Data Broker displays current out-of-state IPV disqualification data.

Related Policy

Explanation of Good Cause, A-1130
How to Project Income, A-1355
Budgeting Options for SNAP Households, A-1355.1
How to Budget Expenses, A-1358
Verification Requirements, A-1370
Medical Deduction, A-1428
Reminders, A-1500
Management, A-1700
Determining the Number of FTL Months Used, A-1920
Disqualifying a Household Member with a Current TANF Out-of-State IPV Disqualification, B-942

A-132 Eligibility Factors

Revision 26-3; Effective July 1, 2026

All Programs

Factors	TANF	SNAP	Medical Programs
Household Composition	X	X	All Medical Programs*
Citizenship	X	X	All Medical Programs*
Social Security number	X	X	TPs 08, 40, 43, 44, 48, 56
Age	X	-	TP 08, TA 31, TPs 32, 33, 34, 35, 43, 44, 45, 48, 56
Relationship	X	-	TP 08, TA 31, TPs 32, 33, 34, 35, 43, 44, 45, 48, 56
Identity	X	X	All Medical Programs except TA 31, TPs 32, 33, 34, 35, 36*
Residence	X	X	All Medical Programs*
Third-Party Resources	X	-	All Medical Programs*
Domicile	X	-	TP 08, TA 31
Deprivation	X	-	
Resources	X	X	TP 56 (children) or TP 32 (children)
Income, Deductions or Budgeting	X	X	All Medical Programs*
School attendance	X	-	TP 08, TA 31
Work registration	X	X	
Management	X	X	TP 08, TA 31
Responsibility Agreement	X	-	

* TP 08, TA 31, TPs 32, 33, 34, 35, 36, 40, 43, 44, 45, 48 and 56.

Note: For medical programs, the eligibility factors noted above do not necessarily apply in all cases.

A-132.1 Medical Programs Hierarchy

Revision 19-4; Effective October 1, 2019

Medical Programs

Texas Works Medical Programs Hierarchy

Step	Eligible Persons	With Income	Type Program Code	Type	Program
1	People ages 18 through 25 who have aged out of foster care in Texas and were enrolled in Medicaid on their 18th birthday	Not Applicable	TP 82	MA	Former Foster Care Children (FFCC)
2	People ages 18 through 20 who have aged out of foster care and: • are not eligible for FFCC (were not receiving federally funded Medicaid when they aged out of foster care); or • who aged out of foster care at age 18 or older, currently reside in Texas, and have had an Interstate Compact on the Placement of Children (ICPC) agreement	At or below program FPL	TP 70	MA	Medicaid for Transitioning Foster Care Youth (MTFCY)
3	Pregnant Women	At or below program FPL	TP 40	MA	Pregnant Women
4	Pregnant women who are nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible	At or below TP 40 FPL	TP 36	MA	Pregnant Women - Emergency
5	Newborn children of Medicaid-eligible mothers up to age 1, including mothers receiving TP 36 for the delivery	Not Applicable	TP 45	MA	Newborn Children (Deemed)
6	Children under age 1	At or below program FPL	TP 43	MA	Children Under Age One
7	Children ages 1 through 5	At or below program FPL	TP 48	MA	Children 1–5
8	Children ages 6 through 18	At or below program FPL	TP 44	MA	Children 6–18
9	Children ages 1 through 5 who are nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible	At or below TP 48 FPL	TP 33	MA	Children 1–5 - Emergency
10	Children ages 6 through 18 who are nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible	At or below TP 44 FPL	TP 34	MA	Children 6–18 - Emergency
11	Children under age 1 who are nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible	At or below TP 43 FPL	TP 35	MA	Children Under Age One - Emergency
12	A parent or caretaker relative caring for a dependent child under age 18 or who meets school attendance requirements who receives Medicaid	At or below program FPL	TP 08	MA	Parents and Caretaker Relatives Medicaid
13	Nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible as a parent or caretaker relative of a Medicaid-eligible child	At or below TP 08 FPL	TA 31	MA	Parents and Caretaker Relatives - Emergency
14	Parents, caretaker relatives and children receiving Medicaid who receive denial due to new or increase in earnings	Above the limits for TP 08	TP 07	MA	Earnings Transitional

Step	Eligible Persons	With Income	Type Program Code	Type	Program
15	Parents, caretaker relatives and children receiving Medicaid who receive denial due to new or increase in spousal support income	Above the limits for TP 08	TP 20	MA	Child Support Transitional
16	Uninsured women ages 18 through 64 diagnosed with breast or cervical cancer and presumed eligible for Medicaid for Breast and Cervical Cancer (MBCC)	Not Applicable	TA 66	MA	MBCC Presumptive
17	Uninsured women ages 18 through 64 diagnosed with breast or cervical cancer	Not Applicable	TA 67	MA	MBCC
18	Children under age 19 and pregnant women	Above the limits for TPs 40, 43, 44, and 48 FPL	TP 56	MA	Medically Needy with Spend Down
19	Nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible as a pregnant woman or child under age 19	Above the limits for TPs 40, 44, or 48 FPL and at or below program limit	TP 32	MA	Medically Needy with Spend Down - Emergency
20	Children under age 19 ineligible for Medicaid due to income	Above the limits for TPs 43, 48, or 44 FPL, and at or below program limit	TA 84	CI	CHIP
21	Unborn children whose mother is ineligible for Medicaid or CHIP due to income or immigration status	Above the limits for TPs 40 and 36, and at or below program limit	TA 85	CI	CHIP - Perinatal
22	Former foster care youth ages 21 through 22 attending school of higher education who: • are not eligible for FFCC; or • who aged out of foster care at age 18 or older, currently reside in Texas, and have had an ICPC agreement.	At or below program FPL	TA 77	Health Care Benefits	Health Care - FFCHE
23	Children under age 1 presumed to be eligible for Medicaid as determined by a Qualified Hospital (QH)	At or below TP 43 FPL	TA 74	MA	Children Under Age One - Presumptive
24	Children ages 1 through 5 presumed to be eligible for Medicaid as determined by a QH	At or below TP 44 FPL	TA 75	MA	Children 1–5 - Presumptive
25	Children ages 6 through 18 presumed to be eligible for Medicaid as determined by a QH	At or below TP 48 FPL	TA 76	MA	Children 6–18 - Presumptive
26	Parents and caretaker relatives presumed to be eligible for TP 08 by a QH	At or below TP 08 FPL	TA 86	MA	Parents and Caretaker Relatives - Presumptive
27	Former Foster Care Children presumed to be eligible for Medicaid by a QH	Not Applicable	TA 83	MA	FFCC - Presumptive
28	Healthy Texas Women	At or below program FPL	TA 41	MA	Healthy Texas Women
29	Pregnant women presumed to be eligible for TP 40 by a QH or Qualified Entity (QE)	At or below TP 40 FPL	TP 42		Pregnant Women - Presumptive

Notes:

- If the pregnant woman or child under age 19 indicates unpaid medical expenses for any of the three months prior to application month or for the application month, determine eligibility under the following programs:
  - TP 56, Medically Needy with Spend Down, for pregnant women and children under age 19 who are ineligible for Medicaid because of income.
  - TP 32 Medically Needy with Spend Down - Emergency, for pregnant women and children under age 19 who are ineligible for Medicaid because of income and alien status.
- Children ages 0 thru 18 who are ineligible for medical programs because of income are tested for CHIP.

Related Policy

Income Limits, C-131
Qualified Hospital/Qualified Entity Procedures for Presumptive Eligibility Determinations, C-1113
Guidelines for Providing Retroactive Coverage for Children and Medical Programs, C-1114
Type Programs (TP) and Type Assistance (TA), C-1150
Former Foster Care in Higher Education (FFCHE), Part F
Medicaid for Transitioning Foster Care Youth (MTFCY), Part M
Medicaid for Breast and Cervical Cancer (MBCC), Part X
Healthy Texas Women, Part W

A-132.2 Guidelines for Pregnant Women

Revision 15-4; Effective October 1, 2015

See A-240, Medical Programs.

A-133 Rights and Responsibilities

Revision 26-2; Effective April 1, 2026

SNAP and TANF

Before completing the interview, staff must ensure that the applicant:

- provides all the information requested on the application;
- reports any changes that occurred since filing the application; and
- reads and understands persons's rights and responsibilities as explained on the application.

TANF

Staff must also ensure that:

- TANF applicants read and understand the rights and responsibilities of the child support program explained on Explanation of Child Support Eligibility Requirements Family Violence and God Cause FAQS (PDF);
- TANF applicants read and understand Form H2580, TANF Employment Services Notice, and receive a copy of the form; and
- TANF applicants read, understand and sign Form H1073, Personal Responsibility Agreement.

SNAP

Staff must provide the applicant with Form H1805, SNAP Food Benefits: Your Rights and Program Rules.

Medical Programs

Before completing the interview, if requested, make sure the applicant:

- completes all sections of the application; and
- reads and understands the person's benefits and responsibilities as explained on Form H1010, Texas Works Application for Assistance — Your Texas Benefits, and Form H1205, Texas Streamlined Application.

A-134 Documentation Guidelines

Revision 13-2; Effective April 1, 2013

A complete list of documentation requirements for determining eligibility can be found at the conclusion of each eligibility section within the Texas Works Handbook. TIERS Data Collection pages handle a vast majority of the required documentation for case records. For the remaining small percentage of documentation still required by policy, staff must include the information in TIERS Case Comments. For documentation that is not captured within the Data Collection pages, a comprehensive guide, The Texas Works Documentation Guide, has been developed. This documentation guide outlines the requirements for documentation that must be entered in TIERS Case Comments.

A-135 Pending Information

Revision 24-1; Effective Jan. 1, 2024

All Programs except TP 40

If the applicant cannot furnish all required proof during the interview or with the application, allow the household at least 10 days to provide the information. The due date must be a business day.

Staff must provide an applicant Form H1020, Request for Information or Action, explaining:

- what is needed;
- the due date for receipt of the information; and
- the date the application must be denied if information is not received.

Form H1020 should include Form H1020-A, Sources of Proof, that corresponds to the verification requested.

Medical Programs

Do not request additional verification if available through electronic data sources unless questionable.

TP 40

Do not allow 10 days for the applicant to provide verification if doing so exceeds the 15 business day processing time frame and verification can be postponed.

Related Policy

Expedited Certification Procedures, A-145
Pending Verification on Applications, B-115
Questionable Information, C-920

A-136 Eligibility Decision and Privacy Notice

Revision 22-1; Effective January 1, 2022

All Programs

After obtaining all required proof, dispose of the application and provide the applicant Form TF0001, Notice of Case Action, detailing the decision.

Medical Programs

HIPAA requires HHSC to provide a notice of privacy practices that explains:

- the person's privacy rights;
- the duties of HHSC to protect the person's health information; and
- how HHSC may use or disclose the person's health information without an authorization. For example, HHSC may share health information with the person's providers to arrange for services or with other government entities to report suspected abuse or neglect.

Provide Form 0401, Notice of Privacy Practices (English PDF), or Form 0401-S, Aviso de Normas Sobre la Privacidad (Spanish PDF), as appropriate, to each household enrolled in a medical program.

Provide Form 0401 or Form 0401S with Form TF0001, Notice of Case Action, to each head of household:

- at initial certification; and
- at recertification after a break in services of more than 180 days.

Form 0403, Explanation to Health Information Privacy Rights, provides a reminder of privacy practices and where to find Form 0401.

Provide Form 0403 (PDF) with Form TF0001 to each head of household:

- at each recertification;
- after a break in services of at least 30 days but not more than 180 days; and
- when a new person is added to a case.

A-137 Prudent Person Principle

Revision 15-4; Effective October 1, 2015

All Programs

The policies and procedures included in the handbook are rules for determining eligibility. It is impossible to provide examples for all policy situations. When staff encounter rare and unusual situations, HHSC encourages them to use reason and apply good judgment in making eligibility decisions. The "prudent person" principle allows staff to make reasonable decisions based on the best available information using:

- common sense,
- program knowledge,
- experience, and
- expertise.

Staff should document the rationale used to make a decision and any applicable handbook references.

A-140, Expedited Service

Body

Revision 26-2; Effective April 1, 2026

SNAP

Use the expedited screening questions on the following forms to screen all applications and redeterminations for expedited service:

- Form H0011, Texas Simplified Application Project (TSAP) for SNAP Food Benefits;
- Form H0011-R, Texas Simplified Application Project (TSAP) for SNAP Food Benefits Renewal;
- Form H1010, Texas Works Application for Assistance; or
- Form H1010-R, Your Texas Works Benefits – Renewal Form.

Redeterminations submitted within 30 days after the certification period ended must be screened for expedited benefits. HHSC staff screen applications and redeterminations received in the local office. Vendor staff screen applications and redeterminations sent to the Document Processing Center by fax or mail. An automated system screens applications and redeterminations submitted online through the Your Texas Benefits website.

Households who meet the test for expedited services are entitled to:

- postpone all verification until after receiving the first month's benefit, except:
  - identity; and
  - proof they meet or are currently exempt from the SNAP ABAWD work requirement if they have already received the maximum number of benefit months without meeting the work requirement; and
- get benefits the same day they apply, if possible, but no later than the next business day.

Expedited Redeterminations

Redetermination applications or renewal packets submitted within 30 days after the certification period has ended must be screened for expedited benefits per the following chart.

Scenario	File Date	Treatment	Eligible for Expedited Service	Prorated
Timely Submitted by the 15th of the last benefit month.	Oct. 10	Timely Recertification	No	No
Untimely within the certification period Submitted between the 16th of the last benefit month and the end of the certification period.	Oct. 25	Untimely Recertification	No	No
Untimely after the certification period Submitted after the certification period between Day 1 and Day 30.	Nov. 10	Untimely Recertification	Yes	Yes
Untimely over 30 days Submitted after the certification period on Day 31 or later.	Dec. 5	Application	Yes	Yes

Exceptions: In the following situations, households may not get benefits within this time frame:

- Applicants or recipients in a drug and alcohol treatment or a group living arrangement facility. Approve benefits so the resident can participate by the seventh day after the application date.
- Joint SNAP/SSI applicants released from public institutions. The Centralized Benefit Services (CBS) section approves benefits so the person can participate by the fifth day after release from the institution.

Late Determinations

Additionally, households may not get benefits within this time frame in late determinations for expedited service. These are households that:

- the agency did not identify as entitled to expedited service when the household filed the application or untimely redetermination after the certification period;
  - expedited processing begins on the day the office becomes aware the household is entitled to this service; and
  - do not enter a late determination date if the agency failed to properly screen the household using the expedited screening questions on the application or redetermination form;
- meet expedited criteria and have a household member who served the minimum employment and training penalty, but the household chose to delay their certification until all disqualified members signed Form H1808, Agreement to Follow SNAP Work Rules;
- require an interview;
  - but HHSC must mail the application or redetermination back to the household for signature; and
  - the late determination date is the date the applicant returns the signed application or redetermination;
- mail or drop off the application or redetermination form.
  - contact the applicant to conduct an interview;
  - if the applicant cannot be contacted by phone, mail Form H1830, Application, Review, Expiration, Appointment Notice, the same day the application or redetermination is screened;
  - the interview must be completed and benefits provided to an eligible household by the seventh calendar day from the file date; and
  - if the household also applies for TANF, schedule a regular TANF appointment on the same notice;
- miss their expedited appointment and contacts office to complete an interview, expedited processing begins the day the household contacts the office for an interview;
- do not provide acceptable proof of identity, or proof of meeting or being exempt from the SNAP ABAWD work requirement, as explained in the beginning of this section, expedited processing begins when the household provides the required proof;
- are not eligible for expedited processing when screened for expedited services at the time of application or untimely redetermination;
  - but meet expedited criteria later in the initial month because of a change in household circumstances after the application; or
  - redetermination form was submitted;
  - the late determination date is the date the eligibility for expedited processing is met; or
- submitted an application or redetermination through the Your Texas Benefits website when the office was closed due to weather-related conditions, flooding or other similar situations so the late determination date is the first business day the office reopens following the office closure.

Notes:

- Enter the late determination date in the eligibility determination system for late determinations caused by the applicant, resulting from a change in the household's circumstances or due to office closures, as explained above.
- Except for delays in screening due to office closure, enter the late determination date only if HHSC, the vendor or the Your Texas Benefits website screened the application on the file date or no later than the next business day.
- The late determination date becomes day zero in determining timeliness on expedited applications.

TP 40

Expedite applications for Medicaid from women applying for current or ongoing coverage due to a pregnancy. These applicants are entitled to:

- have their eligibility determined no later than 15 business days from the date HHSC receives the application; and
- postpone all verification, except identity, until the 30th calendar day from the application file date.

Postponing verification only applies to current and ongoing coverage. For prior coverage, act by the 15th business day. Deny the application if the applicant does not provide verification and reopen denied applications within two years at the applicant's request.

Note: An interview is not required when processing a TP 40 application.

Related Policy

Application Signature, A-122.1
Postponed Verification Procedures, A-145.1
Medicaid Coverage for the Months Prior to the Month of Application, A-830
ABAWD Referral Process, A-1831.1.2
Counting Months Toward Time-Limited Eligibility, A-1950
Regaining Eligibility, A-1960

Residents of D&A Facilities, B-441
Residents of GLA Facilities, B-442

A-141 Expedited Eligibility Criteria

Revision 15-4; Effective October 1, 2015

SNAP

Applicants are entitled to expedited service if they meet one of the following criteria:

- The household's:
  - liquid resources total $100 or less, and
  - countable gross monthly non-converted income totals less than $150. Note: When determining eligibility for expedited services, staff must count the actual amount of TANF the individual actually receives.
- The household's liquid resources plus actual, non-converted countable gross monthly income total less than the most recent monthly expenses for rent/mortgage and utilities. Staff should include the standard telephone allowance for households with a telephone expense.
- The household includes a migrant or seasonal farmworker and meets the destitute criteria listed in A-146, Expedited Policy for Migrant or Seasonal Farmworkers.

An individual who reapplies within the last month of a current certification period is not eligible for expedited service.

TP 40

All applications for Medicaid from women applying for current or ongoing coverage due to a pregnancy are eligible for expedited processing.

A-142 Limit on Expedited Certification

Revision 22-2; Effective April 1, 2022

SNAP

A household may receive expedited services any number of times if, before the expedited certification, the household:

- completes the verification requirements postponed at the last expedited certification; or
- was certified under the usual 30-day processing standards since the last expedited certification.

The household may provide the postponed verification after denial and qualify for expedited services at a later application.

Notes:

- The household may re-apply without submitting a new application until the 60th day after the file date, when an expedited application with postponed verification is denied for failure to provide requested information or verification.
- The household may re-apply without submitting a new application until the 60th day after the file date. Reopen the application using the date the person provided verification as the new file date. If the household submits another application, consider the second application a duplicate. Follow related policy.
- If the information satisfies the verification requirements postponed at the last expedited certification, the household is eligible for expedited services.
- The household may re-apply without submitting a new application until the 30th day following the last benefit month if a redetermination is denied for:
  - failure to provide requested information; or
  - for a missed appointment.
- If the household submits another application, staff must consider the second application a duplicate and follow related policy.

Related Policy

Receipt of Duplicate Application, A-121.2
Reuse of an Application Form After Denial, B-111
Pending Verification on Applications, B-115
Delays Caused by Households, B-122.3

A-143 How to Determine Eligibility for Expedited Service

Revision 24-2; Effective April 1, 2024

SNAP

Step	Situation	Yes	No
1.	Does the applicant's Form H1010, Texas Works Application for Assistance — Your Texas Benefits, and statement meet expedited eligibility criteria policy?	Go to step 2.	Stop, use normal 30-day processing procedures.
2.	Did the applicant already receive SNAP this month?	Stop, use normal 30-day processing procedures.	Go to step 3.
3.	Did the applicant receive expedited service before?	Go to step 4.	Go to step 5.
4.	Did the applicant provide all postponed verifications from previous certification, or did HHSC certify the applicant under normal 30-day processing since the last expedited certification?	Go to step 5.	Stop, use normal 30-day processing procedures.
5.	Was the household denied at redetermination for a missed appointment or failure to provide verification, and the new file date is within 30 days of the last benefit month?	Stop, this application is a duplicate application. Follow reuse of application policy.	Go to step 6.
6.	Does the applicant or AR being interviewed have proof of identity?	Go to step 7.	Not eligible for expedited service until they provide verification of their identity.
7.	If the applicant is an ABAWD and has already received the maximum number of benefit months without meeting the work requirement, did the applicant or AR verify that the applicant meets an exception, exemption, or the ABAWD work requirement?	Go to step 8.	Not eligible for expedited service until they provide verification of meeting the work requirement, an exemption, or an exception reason.
8.	Issue benefits the same day and within seven calendar days from the file date. Postpone all other verification not provided.	N/A	N/A

TP 40

All applications for Medicaid from women applying for current or ongoing coverage due to pregnancy are eligible for expedited processing.

Related Policy

Receipt of Duplicate Application, A-121.2
SNAP Work Requirement Exemptions, A-1822.1
ABAWD Work Requirement, A-1940
Regaining Eligibility, A-1960
Reuse of an Application Form After Denial, B-111
Delays Caused by Households, B-122.3

A-144 Expedited Verifications

Revision 15-4; Effective October 1, 2015

SNAP and TP 40

See A-140, Expedited Service.

A-144.1 Social Security Numbers (SSNs)

Revision 20-2; Effective April 1, 2020

SNAP

Include household members for the initial month, or initial two months if household members are receiving a combined allotment. This is true even if the household members fail to provide or apply for an SSN at the interview or if State Online Query (SOLQ) does not validate a member's SSN at the interview. Follow policy outlined in A-413, Social Security Number (SSN) Validation Through State Online Query (SOLQ), if the SSN does not validate at the interview.

Disqualify people who fail to provide or apply for an SSN without good cause or do not provide information to clear the discrepancy related to a SSN validated with verification code F or X before the next monthly issuance. See A-410, General Policy, for rules for children age six

months or younger and good cause.

TP 40

Certify a pregnant woman by the 15th working day from the application file date to meet expedited processing timeframes even if:

- she fails to provide or apply for an SSN; or
- her SSN is verified with verification code F or X and unable to clear the discrepancy by viewing case documentation or contacting the household by phone. Postpone verification needed to clear the discrepancy.

Deny the woman's eligibility if by the postponed verification due date she fails to:

- provide or apply for an SSN; or
- provide information to clear the discrepancy related to a SSN validated with verification code F or X.

Related Policy

Postponed Verification Procedures, A-145.1
General Policy, A-410
Social Security Number (SSN) Validation Through State Online Query (SOLQ), A-413

A-144.2 Work Registration

Revision 15-4; Effective October 1, 2015

SNAP

Advisors should register the applicant being interviewed for work unless:

- the applicant is exempt from work registration, or
- an AR is applying for the household.

Advisors should register other household members if possible. Advisors should postpone registration for the initial month if it cannot be completed within the expedited time frames.

A-144.3 Citizenship

Revision 16-2; Effective April 1, 2016

SNAP

Household members whose citizenship/eligible alien status is questionable can receive expedited benefits with the household. These household members must provide verification of citizenship/eligible alien status before the next month's benefits are issued or be disqualified.

TP 40

Citizenship/eligible alien status must be verified using policy in A-350, Verification Requirements, for pregnant women who declare to be a U.S. citizen or declare to have an eligible alien status. If a pregnant woman does not provide proof of citizenship or alien status and:

- no other information is required to determine eligibility, she is provided a period of reasonable opportunity as explained in A-351.1, Reasonable Opportunity.
- other information is required to determine eligibility, she is allowed to postpone verification (except identity) until the 30th calendar day from the application file date, as explained in A-145.1, Postponed Verification Procedures. If during that time she returns the other information, but not proof of citizenship or alien status, she is certified, sent Form TF0001, Notice of Case Action, and provided a period of reasonable opportunity at that time.

Related Policy

Reasonable Opportunity, A-351.1

A-144.4 Reserved for Future Use

Revision 20-2; Effective April 1, 2020

A-144.5 Pregnancy

Revision 18-1; Effective January 1, 2018

TP 40

Accept the individual's (pregnant woman's, case name's or AR's) verbal or written statement of pregnancy as verification, unless questionable. The woman's statement would be questionable if the information provided regarding the due date is discrepant, such as the pregnancy start month and pregnancy end month are less than or more than nine months apart or if the woman reports a pregnancy with overlapping start and end months.

The individual's statement of pregnancy must provide the following information:

- Name of woman who is pregnant
- Pregnancy start month and/or anticipated date of delivery
- Number of expected children

If questionable, advisors must verify pregnancy by using:

- Form H3037, Report of Pregnancy; or
- other documentation containing the same information as Form H3037.

The verification must be from an acceptable source such as:

- a physician;
- a hospital;
- a family planning agency; or
- a social service agency.

A physician, nurse, advanced nurse practitioner or other medical professional must sign Form H3037 or another document for it to be considered verification from a medical source. If another medical professional completes the form, the advisor must ensure that information about the supervising physician is provided.

Staff must use the following procedures when certain information regarding pregnancy is not provided on an application for benefits.

- If the only item missing on the application form is the pregnancy start month, staff must count nine months back from the pregnancy end month to determine the pregnancy start month. The pregnancy end month is month zero.
- If the only item missing on the application form is the pregnancy end month, staff must count nine months from the pregnancy start month to determine the anticipated date of delivery. The pregnancy start month is month zero.
- If both the pregnancy start and end months are missing, attempt to obtain the information by phone. If unable to obtain the information by phone, send Form H1020, Request for Information or Action, to request the information.

Related Policy

Verification Requirements, A-870

A-145 Expedited Certification Procedures

Revision 26-2; Effective April 1, 2026

SNAP

Assign normal certification periods even if postponing verifications.

Issue the second month's benefits as a combined allotment, if the household applies after the 15th of the month and benefits are prorated.

Related Policy

Length of Certification, A-2324
Combined Allotments, A-150

TP 40

If an applicant provides the minimum information required to process the application, staff may certify the application before the 15th business day and allow postponed verification.

Deny the application no later than 15 business days if:

- the information given shows the applicant is not eligible; or
- not enough information was given to determine eligibility.

Reopen applications denied because there was not enough information provided if the information is received within 60 days of the file date.

Use the date the information is provided as the new file date. Follow the expedited processing guidelines.

Note: An interview is not required when processing a TP 40 application.

A-145.1 Postponed Verification Procedures

Revision 26-2; Effective April 1, 2026

SNAP

When an expedited application or redetermination is certified with postponed verification, ensure the Form TF0001, Notice of Case Action, includes the following information:

- what verification is needed on a Form H1020, Request for Information or Action;
- the date it is needed; and
- that the person must provide the information before the issuance of benefits for the:
  - second month; or
  - third month, if the person received a combined allotment.

The eligibility determination system identifies and holds benefits for the second month for households not issued a combined allotment or the third month for combined allotment households.

Postponed Verification Procedures Table

If the household furnishes the postponed verification and the	then
second month is on hold,	enter the information and dispose the SNAP EDG within five days or by the first business day of the second month, whichever is later.
third month is on hold for combined allotment situations,	enter the information and dispose the SNAP EDG.

Use the following chart to determine what action to take when information is received after certifying an expedited application or redetermination with postponed verifications:

Information Received During Expedited Processing

If, between the certification date and the date you release the hold	then
• a household provides postponed verification that results in lowered or denied benefits; or • staff discover information that existed on the interview date but the household failed to report, and the information results in lowered or denied benefits,	• determine eligibility and benefits using the new information; and • release the hold and deny or issue lowered benefits effective the hold month providing adequate notice of adverse action.
a household reports a change that occurred after the certification date,	release the hold and issue benefits based on the originally requested information. Work the change using change policy, allowing advance notice of adverse action, if required.

Staff must send a fraud or overpayment referral, if applicable.

If the household does not provide postponed verifications within 30 days of the application date, staff must:

- disqualify the person when appropriate; or
- deny the SNAP EDG for failing to provide postponed information and send the person adequate notice using Form TF0001.

A household denied for failure to provide postponed verification must submit a new application to receive benefits if the household does not provide the postponed verification by the 60th day from the file date. If the household provides the verification by the 60th day, staff must reopen the application using the date the household provided the verification as the new file date.

A person receiving adequate notice of adverse action as noted above cannot receive continued benefits pending appeal.

Related Policy

Changes, B-600
Texas Works Action on an Inadvertent Household Error/Misunderstanding or Intentional Program Violation (IPV), B-472

TP 40

Send Form TF0001, including the:

- eligibility start and end date;
- postponed verifications on a Form H1020; and
- date the verifications are due.

If the person does not provide postponed verification by the 30th day following the file date, staff must provide advance notice of adverse action and deny ongoing coverage. The person must reapply if the verification is not provided by the expiration of the adverse action.

Provide advance notice of adverse action and deny ongoing coverage if the person provides verification by the 30th day following the file date but does not meet eligibility requirements.

Note: Do not deny the EDG if the person is eligible in the application month or one of the three prior months.

Certify the woman on TP 40 following postponed verification procedures when a Medicaid recipient's coverage from a DFPS, SSI, MEPD or MBCC type of assistance is terminated, and unverified pregnancy information is received through an interface.

Note: For children under 19, if verification is not provided by the 30th day, ongoing TP 40 coverage is terminated and the MEPD or MBCC type of assistance coverage is re-established.

Related Policy

Combined Allotments, A-150

A-146 Expedited Policy for Migrant or Seasonal Farmworkers

Revision 15-4; Effective October 1, 2015

SNAP

The expedited processing procedures apply to migrant or seasonal farmworkers except for the following:

- If verifying something other than identity and the source of verification is out of state, the advisor postpones verification until after the household receives the second month's benefit. Advisors should use this procedure for only one two-month postponement during one round-trip from home.
- Households with a migrant or seasonal farmworker are destitute if they have $100 or less countable liquid resources and meet any of the following:
    - The household's only income for the application month is from a terminated source, and the household will not receive any more payments from that source after the application date.

      Advisors should consider terminated income if it is usually received:

        - monthly or more often but will not be received from that source the following month, or
        - at intervals of more than one month but will not be received from that source in the next usual payment period.

      Advisors should not consider terminated income in the following situations:

        - Someone changes jobs while working for the same employer;
        - A self-employed person changes contracts or has different customers without having a break in normal income cycle; or
        - Someone receives regular contributions, but the contributions are from different sources.
    - **Note**: When determining destitute status, advisors do not consider terminated income if a payment from the same source will be received after the file date in the month of application.
    - All household income in the application month is from a new source, and the household will receive income of $25 or less from the first of the month up to and including the 10th day after the application date (or the end of the month if there are not 10 days left in the month).

Income received monthly or more frequently is from a new source if the household did not receive $25 or more from that new source in the 30 days up to and including the application date.

Income received at intervals of more than one month is new income if the household has not received more than $25 from that source between the last usual payment month and the application date.

Advisors count new income received after the application date to determine whether the individual is destitute, but disregard it in determining eligibility and benefits for the month of application.

- The household has a combination of terminated income through the application date and new income after the application date if:
  - there is no other income from the terminated source that month, and
  - the household will receive income of $25 or less from the new source from the first of the month through the 10th day after the application date (or the end of the month if there are not 10 days left in the month).

At recertification, advisors disregard income from a new source in the first month of the certification period if that income will not exceed $25 within 10 days after the individual's usual issuance cycle.

Notes:

- Advisors count an advance of wages for travel expenses as income unless it is a reimbursement.
- Advisors do not consider the advance in determining whether the household is destitute or in determining whether later payments from the employer are from a new source.
- Self-employed farmworkers whose income is annualized are not destitute if they do not receive income each month of the year.
- The grower, not the crew chief, is the farmworker's source of income. An individual who follows a crew chief to a new grower is leaving a terminated source for a new source.

The policies in this section apply to income determinations for destitute applicants at initial and later certifications but only in the first month of any certification period.

A-147 Expedited Eligibility and Enrollment of Active Duty Military Members and Their Dependents

Revision 15-4; Effective October 1, 2015

Medical Programs – All Except Emergency Medicaid and TP 56

All applications for Medicaid from active duty military members and their dependents applying for coverage are eligible for expedited processing.

Active duty refers to military members who currently are serving full time in their military capacity. A military member is defined as someone in the:

- U.S. Armed Forces/Reserves
  - Army
  - Marine Corps
  - Navy
  - Air Force
  - Coast Guard
- National Guard
  - Army
  - Marine Corps
  - Navy
  - Air Force
  - Coast Guard
  - Reserve/Guard
- Army National Guard
- Air National Guard
- State Military Forces/Texas State Guard
  - Texas State Guard – Unless activated by the governor and placed on paid state active duty, these personnel receive no compensation for their time.
  - Texas Army National Guard
  - Texas Air National Guard

When an application for Texas Works medical assistance is received and includes an active duty military member, staff should take the following action on or before the 15th workday of the application file date:

- Provide an interview if requested or required;
- Send/provide Form H1020, Request for Information or Action, to request missing information if no interview was requested or required and the household did not provide information with the application; and
- Send/provide Form TF0001, Notice of Case Action, if the household provided all verification with the application and no interview was requested or required.

Military status is self-declared. Additional verification is not required.

Advisors should use processing time frames stated in B-112, Deadlines, if the household did not provide all required information and verification with the application.

The expedited processing requirement does not apply to TP 56 (Medically Needy with Spend Down) or to Emergency Medicaid for ineligible aliens, and only applies to applications and untimely reviews/renewals.

A household is not eligible for expedited processing if the military member is on active duty because of training as a member of the Reserves, National Guard, or State Military Forces.

When an application consists of a pregnant member and an active duty member, advisors use TP 40 expedited application processing time frames.

Advisors provide expedited processing for a Medicaid application if the budget group includes the needs of an active duty member even if the active duty member is not included in the certified group.

Advisors must not pend an application if the household:

- fails to answer the Yes/No question and name/designation. Advisors must not process the application using expedited time frames. If the Yes/No question is left blank, advisors enter No in the system.
- fails to answer the Yes/No question but provides a name or information that can be used to determine who the active military member is. Advisors should assume that the answer is Yes and process the application using expedited time frames.
- answers Yes to the question but does not provide a name or information that can be used to determine who the active military member is. Advisors must not process the application using expedited time frames.

When an interview is scheduled timely within 15 workdays, but the applicant requests to reschedule the interview, staff should attempt to accommodate the rescheduled appointment within the 15-workday time frame. If, at the household's request, the interview is rescheduled after the 15-workday time frame, staff should document the reason for not scheduling the appointment within the required time frame.

Note: For requested interviews, if the applicant requests to be rescheduled, staff should inform the household that an interview is not required and that the processing of the application can begin without an interview. Staff must not deny an application if the household fails to show for the appointment when an interview is not required.

A-150, Combined Allotments

Body

Revision 26-2; Effective April 1, 2026

SNAP

A combined allotment is when benefits are issued for the initial month and the following month at the same time.

Issue a combined allotment for applications if the:

- benefits are prorated;
- household is eligible for the application month and the following month; and
- application file date is after the 15th of the month.

Issue a combined allotment for redeterminations if the:

- benefits are prorated;
- household is eligible for application month and the following month; and
- file date is after the certification period between Day 16 through Day 30.

Note: Issue a combined allotment if the household is eligible for the first month but not receiving benefits because the proration is less than $10. Issue a combined allotment within expedited service time frames for expedited applications and redeterminations, even if postponing verification.

Inform households receiving combined allotments:

- when the benefits are available;

- that no other benefits are available until the third month; and
- that the third month's benefits are available on the regular issuance schedule.

The eligibility determination system identifies and issues benefits to households eligible for a combined allotment. It holds the third month's benefits if the combined allotment certification has postponed verification.

A-160, Joint TANF-SNAP Applications

Body

Revision 26-2; Effective April 1, 2026

TANF and SNAP

Conduct a single interview when all household members are applying for or receiving SNAP and TANF and apply for both programs at the same time.

Exception: Conduct the unfinished TANF interview later, if necessary, to meet the SNAP expedited processing time limits.

A-161 When Receipt of TANF Is Uncertain

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When TANF eligibility is uncertain, advisors must:

- certify the household for Non-Public Assistance (NPA) SNAP benefits if eligible. Note: If the TANF members have resources, advisors do not exclude the resources for SNAP until the household's TANF EDG is certified (see A-1248, Resources of TANF and SSI Recipients); and
- assign an NPA certification period (see A-2324, Length of Certification).

If TANF is approved later, advisors should process it as a reported change and add the TANF benefit to the SNAP budget as soon as possible. (See A-1324.18, Temporary Assistance for Needy Families [TANF].) Advisors should adjust the certification period to expire when the next TANF periodic review is due. Advisors should send or give the applicant Form TF0001, Notice of Case Action, with the new certification period stated. Exception: One-Time Temporary Assistance for Needy Families (OTTANF), A-1324.11.

If the TANF application is denied later, the advisor should continue SNAP eligibility based on the original application.

A-170, Authorized Representatives

Body

Revision 25-3; Effective July 1, 2025

All Programs

An applicant, person receiving benefits, head of household (HOH), or someone with legal authority to act on their behalf such as a legal guardian or power of attorney, may designate a person or organization as an authorized representative (AR).

An AR must be verified using a(n):

- applicant's or recipient's signature on one of the following HHSC applications for benefits containing the AR designation:
  - Form H0011, Texas Simplified Application Project (TSAP) for SNAP Food Benefits;
  - Form H0011-R, Texas Simplified Application Project (TSAP) for SNAP Food Benefits Renewal;
  - Form H1010, Texas Works Application for Assistance — Your Texas Benefits;
  - Form H1010-R, Your Texas Works Benefits: Renewal Form;
  - Form H1034, Medicaid for Breast and Cervical Cancer;
  - Form H1200, Application for Assistance — Your Texas Benefits;
  - Form H1200-MBI, Application for Benefits — Medicaid Buy-In;
  - Form H1200-MBIC, Application for Benefits — Medicaid Buy-In for Children;
  - Form H1205, Texas Streamlined Application;
  - Form H1206, Health Care Benefits Renewal;
  - Form H1840, SNAP Food Benefits Renewal Form;
  - Form H1841, SNAP-CAP Application;

    - Form H1842, SNAP-CAP Renewal Application;
    - Form H2340, Medicaid for Breast and Cervical Cancer Renewal; or
    - Form H2340-OS, Medicaid for Breast and Cervical Cancer.
- applicant's signature on a Marketplace application for health care benefits that is transferred to HHSC and contains the AR designation;
- legal document that the AR has authority to act on behalf of the applicant or recipient under state law, such as legal guardianship or power of attorney;
- letter designating AR authority and containing the applicant's or recipient's signature, and the name, address and signature of the AR;
- Form H1003, Appointment of an Authorized Representative;
- applicant's or recipient's electronic signature designating the AR on an application, renewal or reported change submitted through YourTexasBenefits.com.

If a person or organization applies on someone's behalf and is not their verified AR, send correspondence to both the unverified AR and the HOH. Then, request verification the household would like to appoint the person or organization as their AR.

- Send the following to the HOH for the case:
    - Form H1020, Request for Information or Action, listing the missing information needed before eligibility can be determined; and
    - Form H1003 to capture the AR designation and the signatures of the applicant and the AR.
- Send the following to the unverified AR:
    - Form H1004, Cover Letter - Authorized Representative Not Verified, explaining what is needed to verify the AR; and
    - Form H1003 to capture the AR designation and the signatures of the applicant and the AR.

For the AR to be verified, either the AR or the HOH must return the completed Form H1003 within 10 days or 30 days from the file date. All missing information listed on the Form H1020 must also be returned on time. If the AR verification is not received by the due date, do not designate an AR.

The AR designation is effective from the date the AR is verified until:

- the applicant or recipient notifies HHSC that the AR is no longer authorized to act on their behalf;
- the AR notifies HHSC that they no longer wish to act as AR for the applicant or recipient;
- there is a change in the legal authority, e.g., legal guardianship or power of attorney, on which the AR's designation is based; or
- the applicant or recipient designates a new AR to act on their behalf. If there is an existing AR designated on a case, the person or organization that the applicant or recipient most recently designated as the AR will replace the existing AR on the case.

Requests to end the designation of an AR must include the signature of the applicant, the recipient or the AR as appropriate. During the redetermination process, the AR cannot end their AR designation if the AR is the person completing and signing the redetermination.

Note: An AR is not automatically a personal representative.

An AR is designated at the case level with access to all benefit information for that case. A verified AR may:

- sign an application on behalf of an applicant;
- complete and submit a renewal form;
- receive copies of notices or renewal forms in the preferred language selected on the application and other communications from HHSC;
- designate a health plan; and
- act on behalf of the applicant or the recipient in all other matters with HHSC.

The applicant, recipient or AR may also request that the AR receive the recipient's Medicaid or CHIP ID card and enrollment-related agency correspondence.

Note: The AR will not receive Healthy Texas Women (HTW) correspondence.

Mailing Address for AR

During the interview, get the AR's complete mailing address if not included on the application form. Record the AR's address on the TIERS Data Collection page, **Household – Authorized Representative**. If the applicant cannot provide a complete mailing address for the AR during the interview or an interview is not required for the program type, do not pend the case. Record the household's mailing address as the AR's address in TIERS.

When an applicant or recipient and their designated AR have the same mailing address, correspondence will only be sent to the AR.

When an applicant or recipient has a legal guardian, correspondence is sent only to the guardian, even if the applicant or recipient and the guardian have different mailing addresses.

Applicants, recipients or ARs who have chosen to receive eligibility correspondence electronically will continue to receive them electronically.

All Programs An AR can be verified using an applicant or recipient's telephonic signature submitted by calling 2-1-1.

SNAP

People disqualified for SNAP benefits because of an administrative disqualification hearing or a nonmember living with the household can be an AR only if:

- no other responsible household member is reasonably able to be the HOH or AR; or
- that person is the only adult living in the household.

HHSC employees involved in certification or issuance of SNAP benefits and retailers authorized to accept SNAP benefits can be an AR only if their supervisor gives written approval.

Related Policy

Electronic Correspondence, A-119.1
Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000
Personal Representatives, B-1212
Establishing Identity for Contact Outside the Interview Process, B-1213
Telephone Contact, B-1213.1
Confidentiality, W-2400

A-171 Protective Payee

Revision 22-3; Effective July 1, 2022

TANF

A grandparent, aunt, uncle, brother or sister who is 25 or older may represent the household in the application and review process upon the relative's request, if staff determine the parent is not using TANF for the child's benefit. In these situations, the parent's signature and designation of the relative as AR in writing is not required on Form H1010, Texas Works Application for Assistance — Your Texas Benefits. When the relative is designated as the protective payee, the relative is automatically the AR.

The Texas Department of Family and Protective Services (DFPS) may also designate a protective payee.

Related Policy

Receipt of Application, A-121
Authorized Representatives, A-170
Verification Requirements, A-180
Documentation Requirements, A-190
Who Is Not Included, A-222

A-172 AR Applying for Household

Revision 15-4; Effective October 1, 2015

All Programs

The AR must be informed about the household circumstances. The individual is liable for any overissuance resulting from inaccurate information that the AR gives, except in situations when drug/alcohol treatment centers or group living facilities act as AR for a SNAP household.

The AR must be an adult.

A-173 AR for Residents of Drug and Alcohol Treatment (D&A) or Group Living Arrangement (GLA) Facilities

Revision 22-1; Effective January 1, 2022

SNAP

For residents of D&A facilities, a facility employee must serve as the AR to apply for the household and to use the benefits.

Residents of GLA facilities may apply:

- for themselves;
- through an AR of their choosing; or
- through an AR employed by the facility.

For D&A and GLA facilities, the AR designated to use SNAP benefits may be a different person from the AR who applies for the household.

Related Policy

Drug and Alcohol Treatment (D&A) or Group Living Arrangement (GLA) Facilities, B-440
D&A or GLA Facility Responsibilities as Authorized Representatives, B-445
Authorized Representatives, B-453

A-174 Abuse by AR

Revision 15-4; Effective October 1, 2015

SNAP

An advisor who suspects an AR of acting against the household's interests must report the circumstances to the advisor's program manager.

A-180, Verification Requirements

Body

Revision 22-3; Effective July 1, 2022

All Programs

When an eligibility determination is requested for multiple programs and the programs allow the same verification sources, staff must use the same verifications for all applicable programs. For example, if a person is applying for SNAP, TANF and Medical Programs and provides acceptable wage verification for SNAP, do not request additional wage verification for TANF or Medical Programs, provided the source is acceptable verification for TANF or Medical Programs.

Make the eligibility decision for each program when all verifications are received for that program.

Related Policy

Data Broker, C-820
Questionable Information, C-920
Providing Verification, C-930

TANF

If a grandparent, aunt, uncle, brother or sister reports a parent is not using TANF benefits for the child’s needs, verify the claim. Designate one of these relatives, provided they are 25 or older and meet TANF relationship requirements, to serve as the protective payee and authorized representative (AR). A child’s cousins, nieces and nephews are not included in the list of potentially eligible relatives.

If the parent requests the relative's removal as protective payee and AR, staff must verify the parent intends to use TANF benefits for the child's needs.

Note: A protective payee is automatically the AR.

Related Policy

Relationship Charts, C-1440

SNAP

Verify the nonprofit status of homeless shelters, if questionable. See IRS documentation that proves the nonprofit status under Section 501(c)(3) of IRS regulations.

A—181 Verification Sources

Revision 22-3; Effective July 1, 2022

TANF

Use the following sources to verify if the parent is using TANF funds for the child's needs, based on a claim from a grandparent, aunt, uncle, brother or sister. Use the same sources when the parent requests the removal of the relative as protective payee and AR:

- Non-related landlord
- Non-related neighbor
- School officials
- Child Protective Services worker
- Person without vested interest in the outcome of the decision

A-190, Documentation Requirements

Body

Revision 26-2; Effective April 1, 2026

All Programs

Document the date and method that advance notice of a home visit was given and the date and time of the visit. An imaged copy of the appointment notice given to the person is enough.

Document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on the application; or
- the application has two received dates.

Document:

- A household requesting more programs after filing an application. This includes the requested program and the date of the request.
- The reasoning to make a prudent person principle decision and any applicable handbook references.
- That form VR30, Texas Voter Registration Application was given to the applicant, AR representative payee under the Agency Use Only section of the application.
- On the application and on Form H1350, Opportunity to Register to Vote, in the Agency Use Only section, the actions taken when a person notifies HHSC that they declined the opportunity to register to vote after receiving Form H0025.
- Detailed information to support the eligibility decision so others can understand all computations and advisor decisions.

TANF and SNAP

For all interviews, staff must document:

- if the person met phone interview criteria;
- if a phone interview was not done; and
- how interpreter services were provided when the application shows the person requested these services, including when staff conducted the interview and acted as an interpreter.

Medical Programs

Document when designated staff request that a child born to a woman in prison be certified for TP 43.

Interviews are not required for medical programs but can be requested by the applicant or recipient. Document how the person's identity was verified if an interview is conducted for a non-interview required program.

TANF

Document the specific reason for designating a protective payee, who is also the authorized representative (AR).

When a grandparent, aunt, uncle, brother or sister requests to be the protective payee, document the:

- information the relative gives to support the claim that the parent is not using the TANF benefit for the child's needs;
- information obtained from collateral contacts, documents or both; and
- decision whether to designate the relative as the protective payee and AR.

SNAP

Document:

- the name and address of the AR;

- that no one else is available, if a person disqualified for intentional program (IPV) or a nonmember living with the household is appointed as AR;
- the tax-exempt status [Section 501(c)(3)] for public or private homeless shelters, if applicable;
- expedited service eligibility by marking the appropriate box on Form H1010, Texas Works Application for Assistance - Your Texas Benefits, and explain if eligibility is questionable;
- the decision on the length of certification and reporting requirements for expedited service EDGs;
- if a migrant is in or out of the workforce;
- the reason for entering a late determination date; and
- the reason why an appointment for an expedited applicant is not scheduled for an interview within the expedited time frame.

Related Policy

Prudent Person Principle, A-137
Registering to Vote, A-1521
Documentation, C-940
The Texas Works Documentation Guide (PDF)

A-200, Household Composition

A-210, General Policy

Body

Revision 24-3; Effective July 1, 2024

TANF

A Temporary Assistance for Needy Families (TANF) certified group:

- Is a person or group of relatives whose needs are included in one Eligibility Determination Group (EDG).
- Must include an eligible child, unless the eligible relative cares for a child who receives:
  - Supplemental Security Income (SSI), Foster Care with Cash or Adoption Assistance with Cash; or
  - SSI Medicaid, and the relative chooses not to request TANF for the child.

Some people are required members of the TANF certified group. The applicant may not choose to exclude a required member from the certified group. If the applicant fails to provide available verification for a required member, deny assistance for the entire certified group.

A TANF-State Program (SP) certified group must contain both an eligible:

- caretaker or parent; and
- second parent.

Households are eligible for TANF-SP if the budget group contains:

- two eligible parents who are certified for TANF;
- one TANF-certified parent and a disqualified parent unless the disqualified parent does not meet citizenship requirements; or
- two disqualified parents unless the disqualified parents do not meet citizenship requirements.

Related Policy

Who is Not Included, A-222
Alien Sponsor's Income, A-1361
A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20, B-480

SNAP

A Supplemental Nutrition Assistance Program (SNAP) unit is one person or a group of people who live:

- together and usually purchase and prepare their food together; or
- with others and intend to purchase and prepare food separately after certification.

When a person is 60 or over and lives with others but cannot purchase and prepare food separately because of a permanent incapacity, the person and their spouse may claim a separate household status if they meet certain criteria. To allow the person and their spouse to claim separate household status, the gross income of the other household members, not including the elderly and disabled person and spouse, must be less than 165 percent of the Federal Poverty Level (FPL) for the number of other people in the household.

To claim a separate household status, the elderly person must:

- prove that they meet the Social Security disability criteria, if questionable; and
- provide verification of the other household member's income.

Note: When granting separate household status, always include required members in the elderly person's household. For example, the elderly person's spouse or children under 22 are always included in the same household unless elderly members have their own SNAP Combined Application Project (SNAP-CAP) EDGs.

Related Policy

Who Is Included, A-231
Noncommercial Roomer/Boarder Payments, A-1323.4.3
Disqualified Members, A-1362
Alien Sponsor's Income, A-1361
Students in Higher Education, B-410
Definition of Disability, B-432
Joint Supplemental Security Income (SSI)-SNAP Applications, B-476
Categorically Eligible Households, B-470

Medical Programs

Use the modified adjusted gross income (MAGI) household composition to determine whose needs, income and expenses are considered when determining eligibility for medical programs. Determine each person's MAGI household composition at an individual level. People living at the same physical address may have different MAGI household compositions. MAGI household composition is based on federal income tax rules.

Exception: Medically Needy with Spend Down has certain exceptions for determining MAGI household composition and income.

A person does not have to file a federal income tax return to apply for medical programs.

Related Policy

How to Determine Spend Down, A-1359

A—211 Relationships Resulting from Termination of Parental Rights

Revision 15-4; Effective October 1, 2015

All Programs

When a court terminates the relationship between a biological or adoptive parent and child, a legal parent/child relationship does not exist between the two individuals.

If a biological or adoptive parent's parental rights to a child are terminated, that parent no longer has a legal parent/child relationship to that child, nor to any of the child's children who are born after the date the parental rights were terminated.

Example: Amy's parental rights to her child Julie are terminated when Julie is 16. Julie already has one child, Jill, at the time Amy's parental rights are terminated. Subsequently, Julie has a second child, Bill. As a result, Amy no longer has a legal relationship with Julie or Bill, but she retains her grandparent relationship to Jill.

Note: A parent whose parental rights have been terminated is not considered the natural parent of their biological child.

Relationships that existed between the child and other relatives of the biological parent are not interrupted or terminated. The only relationship terminated is that of the parent that relinquished his or her parental rights. **Example:** The child's biological or adoptive grandparents, siblings, aunts, uncles, and cousins still have the same relationship to the child they had before the parental rights were terminated.

Related Policy

Child Support and Medical Support Referrals, A-1122.2

A—212 Relationships Resulting from Adoption Procedures

Revision 15-4; Effective October 1, 2015

All Programs

A legal parent/child relationship is created when an individual adopts a child. The adoptive parent/child relationship creates the same relationships with the adoptive parent's relatives that are created with a biological parent/child relationship. **Example:** When a grandparent adopts a biological grandchild, the:

- grandparent becomes the child's adoptive parent, and
- the biological parent becomes the child's adoptive sibling.

A—213 Adoption Household Composition Situations

Revision 15-4; Effective October 1, 2015

TANF

Adoption household composition is determined by the advisor using the following steps:

Steps	Description
1	Identify all eligible children for the applicant/recipient.
2	Include all eligible children in the certified group.
3	Include all siblings of the children included in Step 2 if they are eligible children and cannot be certified separately from their sibling. Include a minor's child at the caretaker/payee's request.

Example 1

If a household consists of the applicant, the applicant's two biological children, ages 15 and 17, the 15-year-old's baby (age 1) that the applicant has adopted, and the 17-year-old's 2-year-old baby, the advisor must:

Steps	Description
1	Identify eligible children: • 15-year-old (daughter of applicant) • 17-year-old (daughter of applicant) • 1-year-old (adopted daughter) • 2-year-old (applicant's grandchild – include at applicant's request)
2	Include in certified group: • applicant • 15-year-old • 17-year-old • 1-year-old
3	Include in certified group at the applicant's request: • 2-year-old

Example 2

If a household consists of the applicant, adopted child (biological grandchild), and the adopted child's half-sibling, not related to the applicant, the advisor must:

Steps	Description
1	Identify eligible children: • adopted child
2	Include in certified group: • applicant • adopted child

Steps	Description
3	N/A – there are no optional eligible children.

Note: For TP 32, TP 33, TP 34, TP 35, TP 43, TP 44, TP 48 or TP 56, the half-sibling can be considered an independent child when determining the child's eligibility for Medicaid. See A-910, General Policy.

A-220, TANF

Body

A—221 Who Is Included

Revision 24-3; Effective July 1, 2024

TANF

The following are always included in the TANF certified group:

1. Eligible Child

An eligible child is a person who meets TANF requirements, is not married per Texas state law, and is:

- under 18; or
- 18 and:
  - is a full-time student, as defined by the school, in high school, attends an accredited general equivalency diploma (GED) class, or regularly attends vocational or technical training as an equivalent to high school attendance; and
  - expects to graduate before or during the month of the child's 19th birthday.

Notes:

- GED is approved only if the class is administered by an accredited institution.
- When removing a child who has turned 18 or 19 from the grant, determine if diversion is needed to account for the needs of the removed child.
- A child certified for foster care, Medicaid only, or adoption assistance Medicaid only is a potentially eligible child.

An emancipated minor is an eligible child if the:

- child meets the TANF age criteria;
- child is not married per Texas state law; and
- caretaker or payee exercises parental control of the child.

Related Policy

Diversions, Alimony, and Payments to Dependents Outside the Home, A-1424

2. Eligible Legal Parent

An eligible legal parent is a legal parent who meets TANF requirements and lives with an eligible child. This includes:

- A parent who is absent solely because of employment or active duty in the U.S. military.
- Parents receiving foster care or adoption assistance services for themselves, but not the child.

Exception: Review No. 6, Minor Parents, below.

Related Policy

Deprivation Based on Absence from the Home, A-1040

3. Siblings

A sibling is a brother or sister of an eligible child, including legally adopted and half-brothers and sisters. Siblings must be certified together if they meet all TANF requirements. If an unborn child will be a required member of the certified group, a special review is set for the first day of the month after the expected delivery month.

Note: Half-brothers or sisters who do not meet the degree of relationship to the caretaker are not eligible to receive TANF benefits. However, they can be certified as an independent child on a separate Medicaid EDG.

Example: The household includes a grandparent, two grandchildren and a half-sibling to the grandchildren. The two grandchildren can be certified for TANF and Medicaid because they meet the required degree of relationship to the caretaker. The half-sibling does not meet the required degree of relationship to the caretaker and cannot be certified for TANF. The half-sibling can be certified as an independent child on a separate Medicaid EDG.

Exception: Review No. 6, Minor Parent, below.

Related Policy

General Policy, A-910

4. Caretaker

A caretaker is any specified relative who:

- is present in the home; and
- supervises and cares for the TANF child.

A caretaker must be the child's:

- father or mother;
- grandfather or grandmother;
- brother or sister;
- uncle or aunt;
- first cousin;
- nephew or niece;
- stepfather or stepmother;
- stepbrother or stepsister; or
- first cousin once removed.

Relationship extends to the:

- Spouse of the listed relatives, even after the marriage has ended in death or divorce, regardless of when the child's birth occurred.
- Degree of great-great for uncles or aunts and nephews or nieces.
- Degree of great-great-great for grandparents.

A caretaker meets the relationship requirement even if a court has jurisdiction over the child or an agency is the child's managing conservator. If a child lives with a managing conservator, the conservator must meet the relationship requirement.

If a child lives with a married relative, not a parent, who wants to be considered the caretaker, eligibility and benefits are determined using:

- normal budgeting procedures for the applicant's income; and
- stepparent budgeting for the income of the applicant's spouse.

If the non-parent caretaker applying for the child is not financially eligible based on their income or resources to receive TANF, then financial eligibility can be determined using only the eligible children.

No one else is included as caretaker if the legal parent is:

- in the home; and
- physically and mentally able to provide care.

Exception: The stepparent may be certified as caretaker if the stepparent wants to be included and the legal parent has a disability. The stepparent and legal parent who has a disability are certified for TANF-SP when the stepparent is included in the certified group.

Related Policy

Relationship, A-520
Stepparent EDGs, A-1366
Relationship Charts, C-1440

5. Second Parent

When a child lives with both legal parents, both parents are included in the certified group. The parent who is not the caretaker is the second parent. The second parent must meet all TANF requirements.

The household may be certified for TANF-SP when:

- both parents are eligible and certified for TANF;
- one parent is eligible and certified for TANF and the other parent is disqualified for one of the reasons listed in A-222, Who Is Not Included, No. 4, Disqualified Members, unless that disqualification is due to not meeting citizenship requirements; or
- both parents are disqualified for one of the reasons listed in A-222, No. 4, unless that disqualification is due to not meeting citizenship requirements.

Related Policy

General Policy, A-1310

6. Minor Parent

A minor parent and child living with the minor parent's parent or siblings may:

- be certified separately if the:
  - minor parent's parent or sibling is not a TANF applicant or recipient; or
  - minor parent cannot be included in their parent or sibling TANF EDG because they are not an eligible child; or
- continue to receive TANF on a separate EDG if the minor parent's EDG was certified before the:
  - month the parent or sibling applied for TANF; or
  - day the minor parent moved into the home with the parent or sibling.

Otherwise, the minor parent must be included as a child with the:

- legal parent(s) who receives TANF or TANF-SP; or
- sibling certified for TANF or TANF-SP as a child.

If the caretaker or payee in the EDG requests TANF for the minor parent's child, the child is included in the EDG with the caretaker or payee and the minor parent.

Exception: A married minor parent is an eligible legal parent and must be certified separately from the minor parent's parents. Review No. 1, Eligible Child, above.

Related Policy

Requirement for Unmarried Minor Parents to Live with an Adult or in an Adult-Supervised Setting, A-930
Unmarried Minor Parent Income, A-1365
Stepparent Budgeting Procedures, A-1366.2

7. Stepparents

A stepparent is not a child's legal parent but is the legal parent's spouse. Stepchildren are deprived of parental support because one legal parent is absent.

Include the stepparent in the certified group only if the stepparent wants to be included and:

- the stepparent is the only parent in the home; or
- both the legal parent and the stepparent are in the home and the legal parent has a disability.

Certify the stepparent and legal parent with disabilities for TANF-SP when the stepparent is included in the certified group. If the legal parent and stepparent live in the home and have mutual children, they must all be included in the same certified group.

Related Policy

Determining Incapacity, A-1051
Resources of Stepparents, A-1247
Stepparent EDGs, A-1366
A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20, B-480

8. People in Nursing Homes

If a member of the TANF-certified group temporarily enters a nursing facility, the person's needs are left in the TANF budget during the nursing facility stay or until the person is certified for Supplemental Security Income (SSI). The person should be referred to the Social Security Office for an SSI eligibility determination.

A—222 Who Is Not Included

Revision 22-3; Effective July 1, 2022

TANF

The following are not included in the TANF-certified group:

1. **Payee**

   A payee is a relative who meets relationship requirements and lives with, supervises, and cares for an eligible child. The payee is authorized to receive the TANF benefits for an eligible child but is not a member of the certified group because the person is a:

   - legal parent who would be a caretaker but is ineligible due to receipt of SSI; or
   - relative other than the legal parent who qualifies as a caretaker except the person:
     - chooses not to be included as caretaker;
     - receives SSI, Foster Care with Cash or Adoption Assistance with Cash payments;
     - is disqualified for an intentional program violation (IPV); or
     - fails to comply with a program requirement that would disqualify a legal parent (see No. 4, Disqualified Members, below).

   Note: A payee who chooses not to be included as a caretaker on one EDG may be a caretaker on another TANF EDG for other related children.

2. **Protective Payee**

   A protective payee must be selected to receive and manage the TANF benefit if the caretaker is not using the TANF payments for the children's benefit.

   The protective payee must be someone who can help the person spend the household's TANF benefits properly. The person receiving TANF must agree to the person designated as the protective payee unless:

   - the Texas Department of Family and Protective Services (DFPS) designates a protective payee; or
   - staff designate a grandparent, aunt, uncle, brother or sister who is 25 or older to be the protective payee because the parent is not using the TANF payments for the child's benefit. Great-grandparents, great-aunts, and great-uncles may be designated as protective payees. Follow TANF relationship requirements.

   The protective payee is automatically the authorized representative (AR).

   The protective payee cannot be a:

   - Texas Health and Human Services Commission (HHSC) employee;
   - person who provides HHSC services to the family; or
   - a relative who is younger than 25 when a relative protective payee is designated by HHSC.
   - A child’s cousin, niece or nephew.

   The protective payee situation must be re-evaluated at each complete redetermination. For EDGs with a:

   - DFPS-requested protective payee. DFPS must be contacted at each complete redetermination to determine whether the protective payee should continue; and
   - grandparent, aunt, uncle, brother or sister designated by HHSC as protective payee. Investigate any alleged report of the relative not using TANF for the child's benefit.

   Note: When designating or continuing a protective payee, notify the recipient and allow an opportunity to appeal.

3. **Representative Payee**

   A representative payee is designated if a person is unable to receive and manage the household's TANF or Medicaid benefits because of incapacity or incompetence. The representative payee must be knowledgeable about the family members and interested in the family’s welfare. The person must designate this representative in writing if physically or mentally capable of doing so.

   A representative payee is automatically the AR. The representative payee may be the AR who assisted in the eligibility process.

4. **Disqualified Members**

   A legal parent is disqualified from the certified group if the person:

   - does not meet citizenship requirements;
   - refuses to comply with Medicaid third-party resource (TPR) requirements;
   - does not comply with Social Security number requirements;

- is found guilty of an IPV;
- fails to timely report the temporary absence of a certified child;
- is a fugitive fleeing to avoid prosecution of or confinement for a felony criminal conviction, or found by a court to be violating federal or state probation or parole;
- is convicted of a felony drug offense (not deferred adjudication) for the possession, use or distribution of a controlled substance as defined in 102(6) of the Controlled Substances Act [U.S. Code (USC) 802(6)] that was committed on or after April 1, 2002, in Texas or another state;
- has received benefits for the total months allowed by the state time limit;
- is a minor parent who fails to comply with the unmarried minor parent domicile requirement; or
- is denied for refusal to cooperate with the program integrity assessment (quality control) process.

Note: A legal parent is permanently disqualified for a felony drug conviction (not deferred adjudication) for an offense committed on or after April 1, 2002.

A child is disqualified from the certified group if the child:

- is a fugitive;
- fails to comply with Social Security number requirements;
- is a minor parent and fails to report the temporary absence of their child; or
- is convicted of a felony drug offense that was committed on or after April 1, 2002.

If the disqualified member wishes to apply for Medicaid, determine which medical program applies to the disqualified household member. If all eligibility requirements are met, certify the person for the appropriate medical program.

When the criminal history report in the Data Broker system indicates the person has been convicted of an offense involving a controlled substance, discuss the situation with the person. If the person claims they are not the person on the criminal history report but the identifying information on the report (name, date of birth, physical description) leads staff to believe the report is correct, or the person disagrees with other information provided in the report, for example, the type of conviction or whether it was a felony or misdemeanor:

- document the person's response in Case Comments;
- proceed with the appropriate EDG action without acting on the criminal history report;
- contact the Office of Inspector General (OIG) Benefits Program Integrity (BPI) Department by emailing the OIG BPI mailbox; and
- document the reason for contacting OIG BPI in Case Comments. Once OIG BPI obtains information to clear the discrepancy, the assigned OIG BPI investigator provides the information via email. Staff responsible for clearing the task must document the results of the OIG BPI's findings in Case Comments. If applicable, enter information in the **Data Collection-Individual Demographic-Conviction/Rehabilitation** page and make an overpayment referral if appropriate.

5. **SSI Recipients**

   A TANF family member is removed from the certified group when the person is certified for SSI. The Social Security Administration (SSA) notifies HHSC by an interface when a TANF recipient is determined eligible for SSI.

6. **Residents in State Supported Living Centers for Individuals with Intellectual Disabilities**

   If a TANF recipient enters a state supported living center for persons with intellectual disabilities, the person’s needs are removed from the TANF grant. If the recipient is the caretaker or payee, the grant continues for the remaining eligible children in another eligible person's name.

7. **Strikers**

   A household's application or ongoing benefits are denied for any month where a certified or disqualified legal parent is participating in a strike.

8. **Foster Care with Cash Payment, Adoption Assistance with Cash Payment, and Permanency Care Assistance (PCA) with Cash Payment recipients.**

   A person receiving these cash benefits is not included in the TANF EDG.

   Note: A person may potentially receive DFPS foster care through their 22nd birthday month. Adoption assistance and PCA are only received through the 18th birthday month unless the family signs an agreement after the youth turns 16. When this occurs, the youth may receive adoption assistance or PCA through their 22nd birthday month.

9. **Ineligible Children**

   A child who is ineligible, such as an ineligible alien child or a child who is not within the required degree of relationship to the adult caretaker or payee, is not included.

Related Policies

Authorized Representatives, A-170
TANF, A-220
Temporary Absence from the Home, A-920
General Policy, A-1210
Disqualified Members, A-1362
Use of TANF Benefits, A-1553
When the Person Signs Form H1073, A-2128.1
Filing an Overpayment Referral, B-770
Relationship Charts, C-1440

A–223 Certifying Children on Non-Parent Caretaker EDGs

Revision 22-3; Effective July 1, 2022

TANF

When an eligible child lives with a relative other than the legal parent, the child is certified on:

- a separate EDG with the relative as a payee when the relative receives TANF for children who are not the child's natural, adopted or half siblings; or
- the same EDG with the non-parent caretaker when the relative:
  - requests it and is not receiving TANF for any other children; or
  - is receiving TANF for children who are the child's natural, adopted, or half siblings.

Certify each other-related child, unless they are siblings, on a separate EDG.

Exception: Other-related children are certified on the same EDG if:

- at least one EDG is ineligible separately;
- the members would be eligible if the EDGs were combined; and
- the relative requests that they be combined.

A child's TANF must not be denied because of the income or resources of a:

- child who is not the child’s natural, adopted, or half sibling; or
- caretaker who is not the child’s parent (for example, a stepparent).

When an EDG is denied because of the income or resources of a non-parent relative caretaker:

- deny the EDG, which includes the caretaker's request for aid; and
- process a separate EDG to determine the child's eligibility without the caretaker.

Note: Households that include a non-parent caretaker are not eligible for TANF-SP. See related policy for more information on the action to take when non-parent relative caretakers must be denied while the other-related children remain eligible.

Related Policy

Stepparent Budgeting Procedures, A-1366.2
OTTANF, A-2411
One-Time TANF for Relatives, A-2412
Documentation Requirements, A-2470
A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20, B-480

A–224 Special Household Composition Situations

Revision 02-8; Effective October 1, 2002

A–224.1 TANF-SP EDGs with Stepchildren or a Parent's Child from a Previous Relationship

Revision 15-4; Effective October 1, 2015

TANF

The following must be included in the TANF-SP EDG:

- a child who lives with a natural/adoptive parent, a stepparent, and a sibling who is the parent and stepparent's mutual child.
- parents and all children, when:
  - the legal parents of a mutual child are not married to each other, and
  - one or both have a child living in the home who is not a mutual child.

If the household is ineligible for TANF-SP because they do not meet other TANF eligibility requirements such as income or resources, the family unit must remain as one filing unit even when stepchildren are included. In this situation, the advisor must determine whether the household meets eligibility requirements for the Medical Programs.

If an active TANF-SP EDG is denied because of earnings or the removal of the 90 percent earned income deduction and the household is receiving TP 08, the Texas Integrated Eligibility Redesign System (TIERS) will deny both the TANF-SP and TP 08 EDGs and create:

- a transitional Medicaid EDG if the certified group meets the eligibility criteria; or
- another Medical Program type of assistance EDG for eligible members if they are not eligible for transitional Medicaid and are otherwise eligible for medical coverage.

Related Policy

Transitional Medicaid Coverage, A-840
General Eligibility Information, A-841
TP 07 Transitional Medicaid, A-842

A–224.2 TANF-SP EDGs with an Other-Related Child

Revision 15-4; Effective October 1, 2015

TANF

Each other-related child living in the family (see A-223, Certifying Children on Non-Parent Caretaker EDGs) is certified on a separate EDG unless the child or other members are ineligible separately. If the child or other members are ineligible separately, the other-related child in the TANF-SP EDG is included. The advisor must ensure that the other-related child has the opportunity to continue receiving TANF when the TANF-SP EDG is denied.

A-230, Supplemental Nutrition Assistance Program

Body

A-231 Who Is Included

Revision 25-3; Effective July 1, 2025

SNAP

The following people must be certified as a Supplemental Nutrition Assistance Program (SNAP) household if they live together:

- **A person under 22 living with their natural, adoptive or stepparents.**
  - Parents and children are considered living together even when they are away from home for employment or educational purposes and return home at least one day a month. This includes college students who are eligible for SNAP.
  - Consider a person 22 starting the month they turn 22.
  - When determining if a person is a required household member, consider the following:
    - The parent-child relationship terminates when parental rights are terminated.
    - The stepparent and stepchild relationship terminates when the marriage between the parent and stepparent terminates, either by death or divorce.
    - When DFPS places a child in foster care, the foster child is considered under parental control of the foster parent. If the foster child's parent moves into the home, the parent, child and foster parent must all be included in the SNAP household.
    - If the parents of a child do not live together and the child lives with each parent part of the month, the child can be certified with either parent. If both parents apply, then certify the child with the parent who provides more meals for the child.
    - A parent or child living with a SNAP-CAP recipient can apply separately. Certify the child as the SNAP head of household.
- **A child under 18 and any nonparent adult household member who has parental control over the child.**
  - A child not under parental control may apply separately if the child purchases and prepares food separately.
  - Consider children 18 years old, starting the month they turn 18.
  - Even if under parental control of a nonparent household member, the following exceptions apply:
    - A foster parent or caregiver can choose to include or exclude a foster care, adoption assistance or permanency care assistance (PCA) payment recipient as a household member in their SNAP certified group.

        - Households with more than one recipient can choose to include some foster care or PCA recipients while excluding others, even if the foster care or PCA recipients are related to each other or related to the foster parent or caregiver.
        - A foster care or PCA recipient who is excluded from their foster parents or caregivers SNAP certified group is not eligible to participate as a separate SNAP household or in another SNAP household.
        - The household may consider a foster child as a boarder instead of a household member.
        - A child under 18 who purchases and prepares food separately can apply separately if they are:
            - married and living with the spouse;
            - emancipated; or
            - not financially or otherwise dependent on another member of the household.
        - A child under 18 living with a SNAP-CAP recipient can apply separately. Certify the minor child as the SNAP head of household.
- **Spouses.** Consider spouses as living together when one spouse leaves the home for employment or educational purposes and returns home at least one day a month.
    - A spouse living with a SNAP-CAP recipient can apply separately,
    - Consider the following for a same-sex marriage. If the couple married:
        - before June 26, 2015, the marriage date is considered June 26, 2015; or
        - on or after June 26, 2015, the marriage date is the date the marriage occurred.

Related Policy

Noncommercial Roomer/Boarder Payments, A-1323.4.3
Foster care and Permanency Care Assistance (PCA) Payments, A-1326.4
Students in Higher Education, B-410
Household Composition, B-475.3

A-232 Who Is Not Included

Revision 15-4; Effective October 1, 2015

A-232.1 Nonmembers

Revision 22-1; Effective January 1, 2022

SNAP

The following are not included in a Supplemental Nutrition Assistance Program (SNAP)-certified group:

1. **Roomers** — Certify a roomer who pays for lodging but not food as a separate household unless the person meets one of the three categories of who is included in a SNAP household, if they live together.
2. **Live-in attendants** — Certify a live-in attendant as a separate household, unless the person meets one of the three categories of who to include in a SNAP household, if they live together.
3. **Boarders** — Boarders in noncommercial boarding houses cannot receive SNAP separate from the household they live with. Boarders who live in a commercial boarding house cannot participate in SNAP. **Note:** A foster parent or caretaker has the option to include or exclude a foster child or adult as a SNAP household member.
4. **Ineligible students** — Students in higher education who do not meet the student eligibility criteria.
5. **New household members** — Do not add new household members certified in another household to the new EDG until they are removed from the previous EDG. **Exception:** Residents in shelters for battered persons may receive two allotments in the same month, if the original benefits issued to the former household included the battered persons, the children and the abuser.
6. **Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP) participants** — Certify people living with an active SNAP-CAP participant as a separate household.
7. **Institutional residents** — Residents who are offered more than half their meals from a facility that is not an approved institution.

Note: Residents of institutions such as homeless shelters, drug and alcohol treatment (D&A) or group living arrangement (GLA) facilities, or family violence shelters are potentially eligible for SNAP, if it is an approved institution. These residents may be certified separately, regardless of how they purchase and prepare meals with other residents. The resident's SNAP household still includes mandatory required SNAP household members, if they live together.

Common examples of institutions are hospitals, nursing homes, public or private homes for persons with a disability, establishments for delinquents and young offenders, group homes for children, penal and correctional institutions, jails, homeless shelters, and students living in a school dormitory where most meals are provided.

Foster placement agencies place some foster children or adults in homes or facilities other than foster parent homes, and are cared for by people who are employees of, or contract with placement agencies. Such facilities usually house multiple foster children or adults. Foster children or adults who reside in these unapproved institutions rather than in the foster parent's home, are considered institutionalized and cannot receive SNAP.

Related Policy

Applications from Residents of a Homeless Shelter, A-116.2
Who Is Included, A-231
Noncommercial Roomer/Boarder Payments, A-1323.4.3
Foster Care and Permanency Care Assistance (PCA) Payments, A-1326.4
Students in Higher Education, B-410
Ineligible Students, B-413
Drug and Alcohol Treatment (D&A) or Group Living Arrangement (GLA) Facilities, B-440
Residents in Family Violence Shelters, B-450
Participation Twice in Same Month, B-454
Prepared Meal Services, B-460
Household Composition, B-475.3
Determining Whether a Person Who Resides in a Facility Is Institutionalized, B-490

A-232.2 Disqualified Persons

Revision 26-3; Effective July 1, 2026

SNAP

The following people would otherwise be required SNAP household members but are disqualified, and cannot participate during their disqualification period. However, the disqualified person's circumstances, income, and resources are considered in determining the household's eligibility and benefit allotment.

Fugitives

People who:

- are fleeing to avoid prosecution of or confinement for a felony criminal conviction; or
- a court found them in violation of federal or state probation or parole.

People with a felony drug conviction

A person with a felony drug conviction, not deferred adjudication, in Texas or another state occurring Sept. 1, 2015 or after. The conviction must be for the possession, use or distribution of a controlled substance per 102(6) of the Controlled Substance Act [21 USC 802(6)]. A person with a felony drug conviction who:

- violates a condition of parole or community supervision, incurs a two-year SNAP disqualification; or
- is convicted of a subsequent felony drug offense in Texas or another state while receiving SNAP, incurs a permanent SNAP disqualification.

Accept the person's statement as verification of a felony drug conviction.

When electronic data sources show the person was convicted Sept.1, 2015 or after, for an offense involving a controlled substance, discuss the situation with the person and:

- if they claim not to be the person on the report, but identifying information on the report such as name, date of birth and physical description lead staff to believe using the prudent person principle that the report is correct; or
- if the person disagrees with other information provided in the report such as the type of offense or if it was a felony or misdemeanor conviction.

If unable to clear the discrepancy between the household's statement and the electronic data sources, staff must:

- document the person's response in TIERS Case Comments;
- proceed with the appropriate case action without the information on criminal history report;
- contact the Texas Office of Inspector General (OIG) by emailing the OIG Benefits Program Integrity (BPI) mailbox; and
- document the reason for contacting OIG BPI in case comments.

The assigned OIG BPI investigator provides the information by email once OIG BPI receives information to clear the discrepancy. Staff responsible for processing this task must document the results of the OIG BPI's findings in TIERS Case Comments. If applicable, staff enter information in the Individual Demographic-Conviction/Rehabilitation page. File an overpayment referral, if appropriate.

Intentional Program Violation (IPV)

People disqualified for an IPV in Texas or another state.

Noncooperation with SNAP Employment and Training (E&T)

People disqualified for failing to cooperate with E&T requirements.

Noncooperation with Social Security number (SSN) requirements

People disqualified for failing to cooperate with SSN requirements.

Ineligible Alien

People who do not have eligible alien status to receive benefits.

SNAP Able Bodied Adult Without Dependents ABAWD Work Requirement

ABAWDs who have received their initial three months of SNAP benefits and who do not meet the ABAWD work requirement.

Related Policy

Prudent Person Principle, A-137
Absence of Proof of Alien Status, A-313
Qualified Alien Status Eligibility Charts, A-340
Failure to Comply, A-420
Disqualified Members, A-1362
Noncooperation with E&T, A-1844
ABAWD Work Requirement, A-1940
After the Three Months of Time-Limited SNAP Eligibility, A-1951
Filing an Overpayment Referral, B-770
IPV Disqualification Penalties, B-912

A-240, Medical Programs

Body

Revision 16-4; Effective October 1, 2016

Medical Programs

The following individuals may be certified for medical coverage if they meet all eligibility criteria:

- children under age 19;
- other-related children under age 19;
- independent children under age 19;
- pregnant women;
- legal parent(s);
- caretaker relatives; or
- spouse of caretaker relatives.

MAGI rules are used to determine financial eligibility for certain Medical Programs. MAGI rules are based on Internal Revenue Service tax rules.

The following criteria are considered when determining the MAGI household composition for Medical Programs:

- tax status;
- tax relationships;
- living arrangements; and
- family relationships.

Tax Status

An individual's tax status must be designated before their MAGI household composition can be determined.

Tax status is based on the individual's self-declaration for what he or she plans to report on his or her federal income tax return for the taxable year in which eligibility for Medical Programs is requested.

Individuals must be designated as one of the following:

- A taxpayer – an individual who plans to file a federal income tax return for the taxable year in which eligibility for Medical Programs is requested and who is not claimed by another taxpayer. Spouses who plan to file a joint or separate federal income tax return are both considered taxpayers.

Note: For MAGI household composition purposes, an unmarried individual who intends to file a joint tax return is considered a taxpayer filing separately. An individual who is unmarried is not considered a taxpayer filing jointly.

- A tax dependent – an individual who plans to be claimed as a tax dependent by a taxpayer.

Note: An individual who is both a taxpayer and tax dependent is considered a tax dependent. **Example:** A college student who plans to file his or her own federal income tax return and expects to be claimed by his or her parents will be considered a tax dependent.

- A non-taxpayer/non-tax dependent – an individual who does not plan to file a federal income tax return in the taxable year in which eligibility for Medical Programs is requested and does not plan to be claimed by a taxpayer.

Tax Relationships

Individuals have a tax relationship to one another if they:

- plan to file a joint federal income tax return;
- are the taxpayer that plans to claim specific tax dependent(s); or
- are a tax dependent of a specific taxpayer.

Individuals do not have a tax relationship to anyone if they:

- do not plan to file a federal income tax return;
- are not the taxpayer planning to claim the specified tax dependent(s); or
- are not a tax dependent of a specified taxpayer.

Living Arrangements

Individuals are not required to live at the same physical address in order to apply for each other if they have a tax relationship, as explained in A-121, Receipt of Application.

Domicile requirements explained in A-900, Domicile, apply to TP 08, Parents and Caretaker Relatives Medicaid. A parent/caretaker relative must reside with a dependent child to receive TP 08 benefits.

A child entering a state hospital may qualify as an independent child. The child may qualify even if ordered by the court into a state hospital. A child is considered an independent child if court ordered into a state hospital because the parent/caretaker relative no longer has care and control. If the parent/caretaker relative admitted the child voluntarily into a state hospital, verification of whether the parent/caretaker relative still has care and control to determine independent child status is required.

An inquiry should be performed prior to certifying an independent child. The child is certified as an independent child if all eligibility criteria are met. The coverage continues for 12 months, even if the child is released from the state hospital. If a child is released from the facility prior to the end of the 12-month period, the address change is processed and coverage is continued.

Determining Custodial Parent

A custodial parent is established based on physical custody and who has legal authority to claim a child as a tax dependent specified in a court order, binding separation agreement, divorce agreement, or custody agreement.

- If there is no order or agreement, or in the event of a shared custody agreement without specifications for filing federal income tax returns, the custodial parent is the parent with whom the child spends most nights. In the event that the child spends an equal amount of nights with both parents, the advisor must make a prudent person decision regarding which parent should be considered the custodial parent.
- If both a custodial parent and a non-custodial parent declare that they plan to claim the same child as a tax dependent on their federal income tax return, the advisor should build the child's MAGI household composition as a tax dependent of the custodial parent.

Family Relationships

Family relationships that impact household composition include:

- marriage;
- parents of children under age 19; and
- siblings under age 19 or a child under age 19.

The tax status of the individual impacts how the family relationship is used in determining MAGI household composition.

Notes:

- For MAGI only applications and renewals, a relationship and tax status of unmarried and intending to file jointly is not an indication that the individual is currently married or that there is a discrepancy in the individual's marital status.
- For integrated applications and renewals that include SNAP or TANF, a relationship and tax status of unmarried and intending to file jointly should be treated as a case clue if marital status is questionable.
- For all applications and renewals, if the client provides a tax document with an indication of marital status that is inconsistent with the marital status that was reported on an application, the discrepancy in the marital status must be resolved.

A household cannot choose to exclude a child from the budget group when determining eligibility for Medical Programs.

The policy in A-241, Budget Group, and A-242, Certified Group, is used to determine whom to include in the budget and certified group.

Related Policy

Children Admitted into State Hospitals, A-922
Verification Requirements, A-940
Documentation Requirements, A-950
Applications for Babies Born to Women in Prison, A-116.3
Eligibility Requirements, A-521

A—241 Budget Group

Revision 12-1; Effective January 1, 2012

A—241.1 Who Is Included

Revision 15-4; Effective October 1, 2015

A—241.1.1 Taxpayer's MAGI Household Composition

Revision 15-4; Effective October 1, 2015

Medical Programs

The following individuals are included in the taxpayer's MAGI household composition:

- The taxpayer;
- The taxpayer's spouse, if the taxpayer and the spouse live together;
- The taxpayer's spouse, if the taxpayer and spouse file a joint federal income tax return; and
- Any individual the taxpayer plans to claim as a tax dependent.

A—241.1.2 Tax Dependent Exceptions

Revision 19-1; Effective January 1, 2019

Medical Programs

If a tax dependent meets any one of the following exceptions, staff must use the non-taxpayer/non-tax dependent rules explained in A-241.1.4, Non-Taxpayer/Non-Tax Dependent's or Tax Dependent with an Exception MAGI Household Composition, (not the tax dependent rules) to build the tax dependent's MAGI household composition:

- The tax dependent is not the taxpayer's spouse or the taxpayer's child (natural, adopted or step) regardless of age;
- The tax dependent is a child under age 19 who lives with both parents who do not plan to file a joint federal income tax return and the child was claimed by one parent; or
- The tax dependent is a child under age 19 who is claimed as a tax dependent only by a non-custodial parent.

For a child claimed as a tax dependent by both parents who are filing jointly, with one parent living outside the home, the child does not meet the third tax dependent exception. Staff must build the child's MAGI household composition using the tax dependent rules explained in A-241.1.3, Tax Dependent's MAGI Household Composition.

A—241.1.3 Tax Dependent's MAGI Household Composition

Revision 15-4; Effective October 1, 2015

Medical Programs

If an individual is a tax dependent and does not meet a tax dependent exception previously listed, the following individuals must be included in the tax dependent's MAGI household composition:

- The tax dependent;
- The individuals in the MAGI household composition of the taxpayer who is planning to claim the tax dependent; and
- The tax dependent's spouse, if the tax dependent and the spouse live together.

A—241.1.4 Non-Taxpayer/Non-Tax Dependent's or Tax Dependent with an Exception MAGI Household Composition

Revision 15-4; Effective October 1, 2015

Medical Programs

If an individual does not plan to file a tax return nor plans to be claimed as a tax dependent, the individual is considered a non-taxpayer/non-tax dependent. All tax dependents who meet an exception – Tax Dependent Exceptions – will build his or her MAGI household composition using the non-taxpayer/non-tax dependent rules.

The following individuals must be included in the non-taxpayer/non-tax dependent's or tax dependent with exception's MAGI household composition **if living together**:

- The individual,
- The individual's spouse,
- The individual's children under age 19, and
- If the individual is a child under age 19:
  - The individual's parents, and
  - The individual's siblings under age 19.

A—241.1.5 Inclusion of the Unborn

Revision 16-4; Effective October 1, 2016

Medical Programs

The expected number of unborn children are included in the MAGI household composition of:

- a pregnant woman; and
- any individual whose MAGI household composition includes a pregnant woman.

Note: When including the expected number of unborn children in the MAGI household composition, the pregnant woman is not required to be certified on a medical program.

Related Policy

General Policy, A-910
Income Limits and Eligibility Tests, A-1341
Who Is Included, D-321
Who Is Not Included, D-322

A—241.2 Who Is Not Included

Revision 15-4; Effective October 1, 2015

Advisors must use the MAGI household composition policy explained in A-241.1, Who Is Included, when determining eligibility for Medical Programs.

A—241.3 Household Composition Situations (Minor Parents, Independent Children, Etc.)

Revision 15-4; Effective October 1, 2015

Advisors must use MAGI household composition policy explained in A-241.1, Who Is Included, when determining eligibility for Medical Programs.

A—241.3.1 Children's Living Arrangements

Revision 22-1; Effective January 1, 2022

Medical Programs

A child is considered institutionalized if the child is residing in a facility:

- that is an organizational part of a governmental entity, such as a county holding facility for juveniles; or
- over which a government unit exercises final administrative control.

A child is not considered institutionalized if the child is residing in a facility that is a:

- publicly operated community residence that serves no more than 16 residents, such as a county emergency shelter;
- non-public facility, such as a group or foster home or a general residential operations facility;
- state hospital; or
- halfway house operated by the Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) that allows residents freedom of movement and association according to the following tenets:
  - residents are not precluded from working outside the facility in employment available to people not under justice system supervision;
  - residents can use community resources at will; and
  - residents can seek health care treatment in the community to the same or similar extent as other Medicaid enrollees.

Related Policy

Child Placed in a Non-Secure Facility, B-544

A—241.4 Family Violence Exemption

Revision 15-4; Effective October 1, 2015

Medical Programs

Individuals may not be able to or may not want to provide information about a member of their MAGI household composition because they fear physical or emotional harm by that person. Individuals who are pended for missing information about a MAGI household composition member who may be a family violence offender can contact HHSC to request the family violence exemption by calling 2-1-1 or visiting a local office.

Advisors must ask the individual requesting the family violence exemption, at the time the exemption is requested, if they want to be designated as the head of household for the case. Advisors must also confirm the address that should be used for agency correspondence and offer to set up an alternate address if needed. Individuals experiencing family violence must be allowed to provide an address for agency correspondence other than the address on the case with the offender.

If the individual wants to pursue the family violence exemption, advisors must determine whether the individual has existing approved Office of the Attorney General (OAG) good cause for TANF or TP 08 as explained in A-1130, Explanation of Good Cause.

- If the individual has existing OAG good cause, no further action is required for the individual. The advisor must select "OAG Good Cause" as the verification source in TIERS.
- If the individual does not have existing OAG good cause, the advisor must make a referral to a family violence specialist at a nearby family violence service provider, following the process explained in A-241.4.1, Referral to a Family Violence Specialist.

A—241.4.1 Referral to a Family Violence Specialist

Revision 15-4; Effective October 1, 2015

Advisors must send the contact information for the nearest family violence shelter to the individual pursuing the family violence exemption using Form H1071, Family Violence Exemption for Medicaid and CHIP. Form H1071 informs the individual how they can claim the family violence exemption and is sent along with Form H1020, Request for Information or Action.

The individual must contact the family violence specialist and explain the need to claim the family violence exemption. After the family violence specialist makes the recommendation, the family violence specialist completes Form H1706, Good Cause Recommendation and Family Violence Exemption, and may mail or fax the form to HHSC, or send the form back with the individual to HHSC. Only a family

violence specialist can recommend the exemption using Form H1706. Form H1706 is due 10 days from the date Form H1020 was sent (or 30 days from the file date, whichever is later).

- If the family violence specialist recommends the family violence exemption, the exemption is granted and will affect all MAGI EDGs on the case by removing the offender from their MAGI household composition.
- If the family violence specialist does not recommend the family violence exemption, the exemption is denied. The advisor must re-pend the MAGI EDGs to give the individual additional time to provide the information that was originally requested for the MAGI household member.
- If Form H1706 is not returned by the due date, the exemption is denied. All pending MAGI EDGs are denied for failure to provide information that was originally requested for the MAGI household member.
- If the client withdraws the request for the family violence exemption, the client must provide the information that was originally requested for the MAGI household member by the due date, or the pending MAGI EDGs are denied.

Once the family violence exemption has been established by a family violence specialist, advisors do not need to re-evaluate the exemption. If the individual contacts HHSC to indicate that they no longer wish to receive the family violence exemption, advisors should update the page by indicating that the exemption has been withdrawn by the client.

The individual continues to receive the family violence exemption until there is a break in eligibility for all MAGI EDGs on the case. If an individual wants to pursue the family violence exemption again after a break in eligibility, advisors must follow the referral process explained in this section.

A—242 Certified Group

Revision 17-1; Effective January 1, 2017

Medical Programs

Each EDG will have one individual in the certified group.

TP 08

Parents and caretaker relatives caring for a dependent child who receives Medicaid.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Pregnant women, children under age 19, and parents and caretaker relatives who are ineligible for ongoing Medicaid because they are non-immigrants, undocumented aliens, or certain legal permanent resident aliens who do not meet the citizenship eligibility requirement but meet all other eligibility requirements. Only a person with an emergency medical condition is certified.

TP 40

Minor or adult pregnant woman unless disqualified from Medical Programs for not complying with TPR or SSN requirements.

TP 43

Children under age 1.

If the child is hospitalized on the child's first birthday, eligibility is continued through the month the hospitalization ends. See A-825, Medicaid Termination, for additional information.

TP 44

Children age 6 to 18. Children are eligible through the month of their 19th birthday.

Note: A child should be certified for TP 48 rather than TP 44 the month of the child's sixth birthday.

If the child is hospitalized on his 19th birthday, eligibility is continued through the month the hospitalization ends. See A-825, Medicaid Termination, for additional information.

TP 45

Children under 12 months old whose mother was eligible for and receiving Medicaid at the time of the child's birth. The mother's eligibility for the child's birth month can be determined retroactively.

TP 48

Children age 1 to 5. Children are eligible through the month of their sixth birthday.

Note: A child should be certified for TP 45 (or 43) rather than TP 48 the month of the child's first birthday.

If the child is hospitalized on the child's sixth birthday, eligibility continues through the month the hospitalization ends. See A-825, Medicaid Termination, for additional information.

TP 56

The following individuals should be certified for TP 56 if they meet all other eligibility criteria:

1. A pregnant woman with household income that exceeds the income limits for TP 40 unless disqualified from Medical Programs for not complying with:
    - TPR requirements; or
    - SSN requirements.
2. Children under age 19 with household income that exceeds the income limits for TP 43, TP 44 and TP 48 unless disqualified from Medical Programs for not complying with:
    - TPR requirements; or
    - SSN requirements.

A-250, Verification Requirements

Body

Revision 24-3; Effective July 1, 2024

SNAP and TANF

Verify fugitive status for people who are fleeing felons or violating their probation or parole.

TANF

There are no verification requirements for household composition. Age, relationship and domicile eligibility criteria are verified to determine people included in the TANF certified group.

Verify out-of-state disqualifications for felony drug convictions.

SNAP

Verify:

- household size and composition, if questionable;
- out-of-state disqualifications for intentional program violations;
- out-of-state disqualifications for felony drug convictions;
- compliance with parole or community supervision for people with a felony drug conviction on or after Sept. 1, 2015, at each application, renewal, and when adding a new household member with a felony drug conviction at a change; and
- if a felony drug conviction is:
    - after another felony drug conviction on or after Sept. 1, 2015; and
    - received while the person was receiving SNAP.

Unless questionable, the household’s statement is acceptable verification of:

- a felony drug conviction; and
- who purchases and prepares meals together.

If the required household members claim to live at separate physical addresses and the information in the case record shows otherwise, including electronic data sources, request additional verification to clear the discrepancy between the household’s statement and the information in the case record. Use Form H1020, Request for Information or Action to request additional verification.

If the required household members claim to live in separate dwelling units at the same physical address, attempt to clear the discrepancy using the county appraisal district (CAD). If the information from the CAD does not clear the discrepancy or shows there is only one dwelling unit at the physical address, request additional verification using Form H1020.

To be considered as living separately, required household members must provide verification that they live in separate dwelling units. If unable to clear the discrepancy, consider the required household members as living together.

A dwelling unit is a home, mobile home, duplex unit, apartment unit, condominium unit or any unit in a multiunit residential structure. A multiunit residential structure is two or more dwelling units in one or more buildings that are:

- under common ownership;
- managed by the same owner, agent or management company; and
- located on the same lot or tract of adjacent lots or tracts of land.

Include required household members on the SNAP EDG who live at the same physical address, regardless of the design of their unit.

Medical Programs

To determine a person's MAGI household composition, each person on the application must provide their tax status, which will identify the person as a taxpayer, tax dependent, a non-taxpayer or non-tax dependent. Additionally, applicants must provide the following information about their tax relationships to one another:

- a taxpayer who plans to claim one or more dependents must provide the name of each dependent;
- a taxpayer who plans to file a joint federal income tax return with a spouse must provide the spouse's name;
- a taxpayer who plans to file a separate federal income tax return from their spouse must provide the name and filing status of the spouse; and
- a tax dependent must provide the name of each taxpayer who expect to claim them.

Note: For a pregnant woman, if tax status information is not available and the client cannot be reached, staff can create a Medicaid for Pregnant Women (TP 40) EDG and certify the pregnant woman by postponing verification of tax status. Using the non-taxpayer and non-tax dependent household policy, request additional information for the tax status on the TP 40 EDG. Staff must verify tax status for a TP 40 EDG after certification if the tax status was not verified by the client during the eligibility determination.

Related Policy

Postponed Verification Procedures, A-145.1
Age/Relationship, A-500
Domicile, A-900
Deprivation, A-1000
Social Security's Criteria for Disability, B-432.1

A-251 Verification Sources

Revision 26-3; Effective July 1, 2026

SNAP and TANF

Verify household composition using the following verification sources:

- building permits;
- court documents;
- county records;
- child welfare records;
- court child support order;
- current school record showing the same address as the specified relative;
- hospital, clinic, health department or private doctor's records;
- juvenile court records;
- juvenile Medicaid tracker, only for those placed or released by the Texas Juvenile Justice Department or Juvenile Probation Department;
- lease agreements;
- marriage license or certificate;
- mortgage statements;
- property deeds;
- statement from clergy, non-relative landlord or non-relative neighbor;
- tax records;
- titles; or
- visual observation of the child.

Note: If a household's statement contradicts information found in the CAD, use prudent person principle to make sure statements from a non-relative landlord, non-relative neighbor or clergy adequately explain the discrepancy.

Verify intentional program violations and felony drug convictions with an out-of-state human services agency.

Verify fugitive status for fleeing felons and probation or parole violators with law enforcement by using a:

- written notification that law enforcement is actively seeking to apprehend the person within the next 30 days; and
- copy of the arrest warrant.

For fugitives who are fleeing felons, the arrest warrant must also contain one of the following National Crime Information Center (NCIC) codes:

- Escape (4901);

- Flight to Avoid (4902); or
- Flight-Escape (4999).

Note: Staff must not pend for, or attempt to get, verification of fugitive status for fleeing felons or probation or parole violators. Verification of fugitive status is provided to HHSC by law enforcement when law enforcement actively seeks to apprehend a person.

TANF

Verify time limits with an out-of-state human services agency.

SNAP

Verify compliance with parole or community supervision for people with a felony drug conviction on Sept. 1, 2015, and after, using:

- Form H1806, Parole or Community Supervision Report; or
- answers to the parole or community supervision compliance questions submitted online through YourTexasBenefits.com or the Your Texas Benefits mobile app when the person who has the felony drug conviction is the same person who:
  - signed the online application;
  - signed the renewal; or
  - submitted the change.

Verify subsequent felony drug convictions while receiving SNAP using:

- criminal history in Data Broker;
- an out-of-state human services agency; or
- TIERS inquiry.

Medical Programs

Verify MAGI household composition, including a person's tax status and tax relationships, using client statement unless questionable.

Related Policy

Prudent Person Principle, A-137
Questionable Information, C-920
Providing Verification, C-930

A-260, Documentation Requirements

Body

Revision 24-3; Effective July 1, 2024

TANF and TP 08

Document the reason why people living in the home are not included on the EDG.

Refer to relationship, domicile and deprivation policy for other verification and documentation requirements.

TANF

Document:

- the specific reason for designating a representative payee or protective payee;
- the basis for giving separate household status to married minors;
- the name and phone number of an out-of-state human services employee who provides information;
- months of TANF cash assistance received in other states since October 1999 by an adult household member;
- the household was informed of the one-time payment at application and if the caretaker requested it or declined it; and
- a relative caring for a related dependent child or children receiving TANF was informed of One-Time TANF for Relatives at application or periodic review if the relative is potentially eligible and if they requested it or declined it.

SNAP

Document:

- an explanation of the household composition;

- the basis of granting separate household status;
- the applicant's or recipient's response to electronic data sources or other information in the case record and the reason the person disagrees with the information, if applicable;
- the information from the county appraisal district (CAD) and the attempt to clear the discrepancy;
- the reason for an OIG referral resulting from the Data Broker criminal history record for a felony drug conviction;
- the result of OIG's findings;
- the disqualification status of any disqualified household member;
- the name and phone number of an out-of-state human services employee who provides verification;
- the name of the household member currently disqualified for an intentional program violation (IPV) in another state; and
- the number of any countable months of benefits received in another state as an able-bodied adult without dependents (ABAWD).

Related Policy

Documentation Requirements, A-540
Documentation Requirements, A-950
Disability Verification, A-1080
Disqualifying a Household Member with a Current SNAP Out-of-State IPV Disqualification, B-941
The Texas Works Documentation Guide (PDF)

A-300, Citizenship

A-310, General Policy

Body

Revision 13-2; Effective April 1, 2013

All Programs

U.S. citizens and certain legally-admitted alien residents are eligible for benefits if they meet all other eligibility criteria.

A person born in the 50 states, District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, America Samoa, Swain's Island or Northern Marianna Islands is considered a U.S. citizen.

A person born abroad to at least one U.S. citizen parent may claim derivative citizenship. See How to Verify Citizenship, A-351.4.

Exception: Undocumented aliens applying for Emergency Medicaid do not have to meet citizenship status eligibility requirements.

A-311 Alien Status Policies

Revision 22-2; Effective April 1, 2022

All Programs

Before certifying any alien resident, ensure that the U.S. Citizenship and Immigration Services (USCIS):

- legally admitted the person to live in the United States; and
- they meet the definition of a "qualified immigrant".

Review the person's USCIS document(s) and the Qualified Alien Status Eligibility charts to determine the programs where the person is potentially eligible. Disqualify a person who does not have acceptable alien status. Check USCIS documents for expiration dates. An expired document is not acceptable.

Exception:

Do not disqualify the person:

- if the person provides an expired USCIS document; and
- the Systematic Alien Verification for Entitlements (SAVE) response indicates the person is a Lawful Permanent Resident – Employment Authorized; and
- the 'Date Admitted To' response shows 'Indefinite', the person meets alien status criteria.

Notes:

- Use the TANF and Medical Programs Alien Status Eligibility Charts to determine Emergency Medicaid eligibility for aliens without acceptable status.
- Before disqualifying a person with an expired document, check the expiration date of the document in SAVE. USCIS automatically extends certain I-766, Employment Authorization Documents, for up to 180 days when USCIS receives a renewal application for the document. When this occurs, SAVE displays the new expiration date. Do not disqualify the person if SAVE shows the I-766 is current.

Related Policy

Definition of Qualified Immigrant, A-311.1
Qualified Alien Status Eligibility Charts, A-340
Verification of Alien Status, A-352
Verifying Alien's USCIS Documents, A-355

A-311.1 Definition of Qualified Immigrant

Revision 22-2; Effective April 1, 2022

All Programs

The USCIS defines a qualified immigrant as an alien in one of the following categories:

- Asylee;
- Battered Alien;
- Conditional Entrant;
- Cuban or Haitian Entrant;
- Deportation (or Removal) Withheld;
- Iraqi and Afghan Special Immigrants (SIV);
- Lawful Permanent Resident (LPR);
- Parolee;
- Refugee;
- Special Immigrant Conditional Permanent Resident (SI CPR); or
- Trafficking Victims.

Note: The Qualified Alien Status Eligibility Charts list all the above categories.

Related Policy

Qualified Alien Status Eligibility Charts, A-340
How to Determine Eligibility for Battered Aliens, A-343

A-312 Contact with the U.S. Citizenship and Immigration Services (USCIS)

Revision 15-4; Effective October 1, 2015

TANF and SNAP

An illegal alien is one who has received a final deportation order. Advisors must report applicants who are illegal aliens to USCIS in writing. The supervisor must sign a written notification and send it to the nearest USCIS office, which can be found at https://egov.uscis.gov/office-locator.

Except for using the SAVE Verification Information System (VIS), advisors may contact USCIS on behalf of an alien only at the individual's written request. If the alien does not wish to contact USCIS or give the advisor permission, the advisor must advise the household that the household may be certified without the alien (that is, disqualify the alien).

A-313 Absence of Proof of Alien Status

Revision 24-2; Effective April 1, 2024

SNAP and TANF

Disqualify a household member from the certified group if the member does not have or refuses to provide proof of alien status. The remaining members of the group are certified if they meet all eligibility requirements.

Related Policy

TANF — Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits, A-1362.1

SNAP — Budgeting for Members Disqualified for Citizenship, SNAP ABAWD Work Requirement or Noncompliance with Social Security Number Requirements, A-1362.3

TANF

If the applicant cannot provide verification of eligible alien status for a child, the child is considered ineligible rather than disqualified.

Medical Programs

If the applicant cannot provide verification of eligible alien status after the period of reasonable opportunity, the applicant is ineligible for benefits.

Required household members are included in the budget group or Modified Adjusted Gross Income (MAGI) household composition, even if the household members do not have proof of their alien status.

Related Policy

Who is Included, A-241.1
Reasonable Opportunity, A-351.1

A-314 Re-verification of Alien Status Due to a USCIS Document's Expiration Date

Revision 18-1; Effective January 1, 2018

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must re-verify the alien's USCIS card if the:

- USCIS document has expired; and
- alien wants to continue receiving or reapplies for benefits.

Advisors must allow an alien 10 days to update the card with the USCIS. If the individual cannot provide an updated document or proof within 10 days, the alien is disqualified until the individual provides a valid USCIS card or proof of application for a new card.

Exception: If the individual's USCIS document is expired and the SAVE response shows the individual is a Lawful Permanent Resident - Employment Authorized and the Date Admitted To response is Indefinite, the individual meets alien status criteria. These individuals must not be disqualified.

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

When a certified alien's USCIS document expires before the periodic review date, the advisor must schedule a special review the month the document expires.

SNAP

Advisors must set the certification period to end the same month the USCIS document expires or schedule a special review for the month the document expires.

For streamlined reporting (SR) households, the advisor must not set a special review for the month the document expires. A document that expires during the SR certification period does not cause an individual to lose eligibility. The advisor may assume that the household will renew the document upon expiration and re-evaluate at the next certification.

Related Policy

Alien Status Policy, A-311

A-315 Definition of Public Charge

Revision 15-4; Effective October 1, 2015

All Programs

A public charge is defined by law as an alien who has applied for and received public cash assistance for income maintenance, such as Temporary Assistance for Needy Families (TANF) cash assistance, Supplemental Security Income (SSI) or institutionalization for long-term care at government expense, such as nursing home care.

A-315.1 Providing Information to Immigrants Regarding Public Charge

Revision 15-4; Effective October 1, 2015

TANF

If an immigrant inquires, staff must inform the individual that receipt of TANF cash benefits places the immigrant at risk of being considered a public charge and the individual may lose his or her immigrant status.

Exception: According to USCIS, the following individuals are exempt from public charge:

- refugees,
- asylees,
- asylum applicants,
- refugees and asylees applying for adjustment of permanent resident status,
- Cuban/Haitian entrants and parolees,
- Special Immigrant Visa holders from Iraq and Afghanistan,
- Amerasian immigrants (for their initial admission),
- individuals granted relief under the Cuban Adjustment Act (CAA),
- individuals granted relief under the Nicaraguan and Central American Relief Act (NACARA),
- individuals granted relief under the Haitian Refugee Immigration Fairness Act (HRIFA),
- individuals applying for a T Visa,
- individuals applying for a U Visa,
- individuals who possess a T Visa and are trying to become a permanent resident,
- individuals who possess a U Visa and are trying to become a permanent resident,
- individuals who have been certified by the Office of Refugee Resettlement as a victim of trafficking (prior to being issued a T Visa by USCIS),
- applications for Temporary Protected Status (TPS), and
- certain applicants under the LIFE Act Provisions.

SNAP and Medical Programs

If an immigrant inquires, the advisor must assure the individual that receipt of Supplemental Nutrition Assistance Program (SNAP) and/or medical program benefits does not place the immigrant at risk of becoming a public charge.

A-315.2 Receiving Other Benefits

Revision 15-4; Effective October 1, 2015

All Programs

There are other public assistance programs that immigrants may apply for that do not result in public charge considerations. These programs include: Special Supplemental Nutrition Program for Women, Infants and Children (WIC), immunizations, prenatal care, testing and treatment of communicable diseases, emergency medical assistance, emergency disaster relief, housing assistance, and child care.

A-316 Sponsored Alien

Revision 15-4; Effective October 1, 2015

All Programs

A sponsored alien is an individual who has been sponsored by a person who signed an affidavit of support (USCIS Form I-864 or I-864-A)on or after December 19, 1997, agreeing to support the alien as a condition of the alien's entry into the U.S.

A sponsor is someone who brings family-based or certain employment-based immigrants to the U.S. and demonstrates that he or she can provide enough financial support to the immigrant so that the individual does not rely on public benefits.

If necessary, advisors use the SAVE system to verify whether an alien has a sponsor. The SAVE system, through additional verification, can provide the sponsor's name and address.

A-316.1 Providing Verification of the Alien's Sponsor Income and Resources

Revision 16-2; Effective April 1, 2016

TANF, SNAP, TP 08, TP 43, TP 44, TP 48, TP 40, TP 07, TP 20, TP 56, TP 70, TA 84 and TA 85

For cases involving aliens and their sponsors, the alien is responsible for getting all verification from the sponsor and sponsor's spouse.

Request the following information from the alien if not otherwise available through Systematic Alien Verification for Entitlement (SAVE) or Texas Integrated Eligibility Redesign System (TIERS) inquiry or case documentation:

- Alien sponsor name,
- Alien sponsor date of birth,
- Alien sponsor Social Security number,
- Alien sponsor earned income,
- Alien sponsor unearned income,
- Alien sponsor self-employment income,
- Alien sponsor resources (if applicable, as explained in A-1245, Resources of an Alien's Sponsor), and
- Alien sponsor citizenship status or alien number if the sponsor is a lawful permanent resident.

The income and resources (if applicable) of an alien's sponsor (and the sponsor's spouse if the spouse also signed an affidavit of support, USCIS Form I-864) must be counted (deemed) as belonging to the sponsored alien, regardless of actual availability when determining the sponsored alien's eligibility and benefit amounts.

Deeming of the sponsor's income and resources (if applicable) to the sponsored alien lasts until the:

- sponsored alien becomes a naturalized citizen,
- sponsored alien can be credited with 40 qualifying quarters of work, or
- sponsor dies.

Sponsored aliens not subject to sponsor deeming are:

- children under age 18;
- sponsored aliens who are ineligible for benefits (examples include those who are disqualified from getting benefits or those considered non-members, such as students who do not meet SNAP student eligibility criteria);
- battered spouses or children;
- refugees, parolees, asylees, people granted withholding of deportation, Amerasians, trafficking victims, and Iraqi and Afghan special immigrants;
- aliens whose sponsor has not signed an affidavit of support;
- aliens whose sponsor is in the same household/Modified Adjusted Gross Income (MAGI) household composition; and
- indigent aliens.

TANF, TP 08, TP 43, TP 44, TP 48, TP 40, TP 07, TP 20, TP 56, TP 70, TA 84 and TA 85

If the sponsored alien fails to provide sponsor verification by the required date in B-115, Pending Verification on Applications, the alien's application is denied.

Note: Resources of an alien sponsor must only be verified if resources are counted for that program, as explained in A-1245.

SNAP

If the sponsored alien fails to provide sponsor verification by the required date in B-115, the sponsored alien is disqualified until the alien provides the proof. If eligible, remaining household members may participate while the alien is disqualified. If the disqualified alien later provides the proof, the advisor processes it as a reported change. The Eligibility Determination Group (EDG) is denied if the household fails to provide proof of the disqualified alien's own income.

Related Policy

Resources of an Alien's Sponsor, A-1245
Alien Sponsor's Income, A-1361

A-320, Definitions of Military Connection

Body

Revision 12-4; Effective October 1, 2012

A-321 Veteran

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

A veteran is eligible for benefits because of a military connection if the veteran is:

- "honorably discharged" from the armed service, and
- meets the minimum active duty requirement of:
  - 24 months of continuous active duty, or
  - the full period the person was called or ordered to active duty.

Individuals who served in the Philippine Commonwealth Army during World War II, or as Philippine scouts following the war, are veterans for purposes of eligibility.

Related Policy

Verification of Veteran Status, A-353.1

A-322 Active Duty Military Member

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

An active duty military member is eligible for benefits because of a military connection if currently on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps or Coast Guard. It does not include full-time National Guard duty.

Active duty training as a member of the Reserves, Army National Guard, or Air National Guard does not establish eligibility for the individual. The advisor must determine that training is not the reason the reserve member is on active duty.

Related Policy

Verification of Active Duty Military, A-353.2

A-323 Spouse or Minor Unmarried Dependent Child of Veteran or Active Duty Military Member

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

A spouse is eligible for benefits because of a military connection if the individual is currently married to a veteran or active duty military member. A minor unmarried dependent child under age 18 is eligible.

Related Policy

Verification of a Spouse or Minor Unmarried Dependent Child of a Veteran or Active Duty Military Member or Unmarried Surviving Spouse of a Deceased Veteran or Active Duty Military Member, A-353.3

A-324 Unmarried Surviving Spouse of a Deceased Veteran or Active Duty Military Member

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

To meet the alien eligibility status as a surviving spouse of a deceased veteran or an active-duty military member, the spouse must not have remarried, and the marriage to the veteran or active duty military member must fulfill one of the following requirements:

- lasted at least one year;
- occurred within 15 years after the period of service in which the injury or disease that resulted in the death of the veteran or active duty member ended; or
- a child was born between the surviving spouse and the veteran or active duty member, either during or before the marriage.

Related Policy

Verification of a Spouse or Minor Unmarried Dependent Child of a Veteran or Active Duty Military Member or Unmarried Surviving Spouse of a Deceased Veteran or Active Duty Military Member, A-353.3

SNAP

If a currently certified surviving spouse remarries, the spouse retains eligible alien status through the end of the current certification period.

A-330, Lawful Permanent Resident and 40 Qualifying Quarters of Social Security Coverage

Body

Revision 18-1; Effective January 1, 2018

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

LPRs admitted prior to Aug. 22, 1996, meet the alien eligibility requirement by having 40 qualifying quarters of social security coverage. LPRs admitted on or after Aug. 22, 1996, meet the alien eligibility requirement by having 40 countable qualifying quarters of social security coverage, **if five years** have passed since the legal date of entry. An LPR does not have to meet the 40-quarter requirement, including the five-year wait, if any of the following apply.

The alien:

- has a military connection;
- entered the U.S. with a status described in Chart C of A-342, TANF and Medical Programs Alien Status Eligibility Charts, and meets the eligibility criteria for refugees, asylees, etc., or meets the criteria in A-343, How to Determine Eligibility for Battered Aliens; and
- is a qualified immigrant or non-immigrant child age 18 and under who lawfully resides in the U.S. with a status described in Chart D of A-342, TANF and Medical Programs Alien Status Eligibility Charts.

SNAP

LPRs with 40 qualifying quarters meet the alien eligibility requirement. An LPR does not have to meet the 40-quarter requirement if the alien:

- lawfully resided in the U.S. as a qualified immigrant for five years from the date of entry;
- was admitted to the U.S. on or before Aug. 22, 1996, and was age 65 or older on Aug. 22, 1996;
- meets the definition of disability in B-432, Definition of Disability (regardless of when the alien acquired a disability or entered the U.S.);
- is currently under age 18 (regardless of when the alien entered the U.S.);
- has a military connection; or
- qualifies as a refugee, asylee, etc., as shown in Chart A of A-341, SNAP Alien Status Eligibility Charts.

Related Policy

Verifying 40 "Qualifying Quarters," A-354

A-331 Whose Quarters Can Be Considered

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

For purposes of establishing eligibility through the use of the 40 "qualifying quarters" requirement, LPRs are credited with quarters of earnings for the:

- LPR,
- LPR's current spouse or deceased spouse regardless if the spouse is an LPR or a U.S. citizen, and
- LPR's parent before the LPR turned age 18. This includes adoptive parents or stepparents.

Note: All of the quarters earned by the LPR's parents through the quarter the LPR turns age 18 are counted.

When determining whether to credit the quarters to an individual's spouse, the advisor must count quarters earned:

- beginning with the quarter from the date of marriage, and
- by a deceased spouse only if the marriage was not terminated before the spouse died.

Quarters earned by divorced spouses for either ex-spouses do not count. LPRs who divorce after certification retain their eligible alien status through the end of the current certification period. This also applies to stepchildren.

Until the quarter a child turns age 18, to meet the 40-quarter requirement, a child may use quarters earned by:

- natural or adoptive parents;
- stepparents from the date of marriage to the legal parent; and
- deceased parents.

Related Policy

Verifying 40 "Qualifying Quarters," A-354

A-340, Qualified Alien Status Eligibility Charts

Body

Revision 23-2; Effective April 1, 2023

An alien's eligibility is based on the USCIS status and other criteria as shown in A-341, SNAP Alien Status Eligibility Charts, and A-342, TANF and Medical Programs Alien Status Eligibility Charts.

A-341 SNAP Alien Status Eligibility Charts

Revision 23-2; Effective April 1, 2023

Chart A

If the qualified alien was admitted as a/an …	and the USCIS document provided is a/an …	then the alien is …
Refugee	• ***I-551**, Permanent Resident Card, annotated with R8-6, RE-1 thru RE-9; • **I-94**, Arrival/Departure Record, annotated with INA Section 207 or Refugee; • Original certification letter from the Office of Refugee Resettlement (ORR); • **I-766**, Employment Authorization Document, annotated with Code A3;	eligible from date of entry.
Asylee	• ***I-551**, Permanent Resident Card, annotated with AS-6 thru AS-8; • **I-94**, Arrival/Departure Record, annotated with INA Section 208 or Asylee; • **I-766**, Employment Authorization Document, annotated with Code A5; • USCIS letter from Asylum Office; • Order from an immigration judge granting asylum;	eligible from date of entry.
Deportation Withheld	• **I-94**, Arrival/Departure Record, annotated with INA Section 243(h) or 241(b)(3); • **I-766**, Employment Authorization Document, annotated with Code A10; • Order from an immigration judge showing deportation withheld under INA Section 243(h) or 241(b)(3). Consider the date of entry as the date	eligible from date of entry.

If the qualified alien was admitted as a/an …	and the USCIS document provided is a/an …	then the alien is …
	the status was assigned.	
Cuban or Haitian Entrant	• ***I-551**, Permanent Resident Card, annotated with R8-6, CH-6, CU-6, CU-7; • **I-94**, Arrival/Departure Record, annotated with INA Section 212(d)(5) or Cuba/Haitian Entrant; • **I-94**, Arrival/Departure Record, annotated with INA Section 240, Pending Hearing – Cuban granted parole for one year; • **I-94**, Arrival/Departure Record, annotated as Public Interest Parole; • **I-766**, Employment Authorization Document, annotated with Code C8; • Receipt from INS Asylum Office indicating filing of Form I-589, Application for Asylum; • **I-220A**, Order of Release on Recognizance; • **I-862**, Notice to Appear.	eligible from date of entry.
Haitian Orphan	• **I-94**, Arrival/Departure Record, indicating the person has humanitarian "parole" status admitted after Jan. 12, 2010; • **Immigrant visa** indicating the person was lawfully admitted for permanent residence; • ***I-551**, Permanent Resident Card, annotated with Status Code CH-6;	eligible from date of entry.
Amerasian	• ***I-551**, Permanent Resident Card, annotated with one of the following Status Codes: **AM-1, AM-2, AM-3, AM-6, AM-7** or **AM-8**;	eligible from date of entry.
Victim of Severe Trafficking	• Derivative T Visa annotated with **T-1**; • Derivative T Visa annotated with **T-2, T-3, T-4, T-5** (family members of a victim of severe trafficking);	eligible up to four years from date of entry or until the law enforcement extension expires.
Afghan or Iraqi Special Immigrant	**Passport** with a Machine Readable Immigrant Visa (MRIV) or with a stamp noting that the person has been admitted under a special immigrant visa (IV) category with one of the following codes: • **SI-1** or **SQ-1** for the principal applicant; • **SI-2** or **SQ-2** for the spouse of principal applicant; • **SI-3** or **SQ-3** for the unmarried child under 21 of principal applicant; and a • Department of Homeland Security(DHS) stamp or notation on passport or I-94, showing date of entry. This includes a DHS or CBP, or DHS or USCIS temporary Form I-551 Alien Documentation Identification and Telecommunication (ADIT) stamp. **Or** ***I-551** annotated with an IV code for category **SQ-1**, **SQ-2** or **SQ-3**. **Or** **I-765**, Employment Authorization Document (EAD), receipt notice with code **SQ1**, **SQ2**, **SQ3**, **SQ6**, **SQ7** or **SQ8**. **Or** **I-766**, Employment Authorization Document (EAD), with code **SQ1**, **SQ2**, **SQ3**, **SQ6**, **SQ7** or **SQ8**. **For special immigrants who are Special Immigrant Parolees (SI or SQ Parole):**	eligible from date of entry.

If the qualified alien was admitted as a/an …	and the USCIS document provided is a/an …	then the alien is …
	I-94 noting Special Immigrant Status (SI/SQ) Parole Section 602 (B)(1) AAPA/Sec 1059(a) NDAA 2006 **or** SQ4/SQ5 SI Parolee notation signed and dated by USCIS officer: • **SQ-4** for the principal applicant; • **SQ-5** for the spouse or unmarried child under 21 of principal applicant. **For special immigrants who are adjusting their status to LPR status in the U.S.:** ***I-551**, Permanent Resident Card, annotated with one of the following status codes: • **SI-6** or **SQ-6** for the principal applicant, • **SI-7** or **SQ-7** for the spouse of principal applicant; or • **SI-8** or **SQ-8** for the unmarried child under 21 of principal applicant. Special immigrants may also demonstrate nationality with an Afghan or Iraqi passport. **For special immigrants who are conditional permanent residents (SI CPRs) adjusting their status to LPR status in the U.S.:** **Passport** with a MRIV, or DHS or CBP stamp noting admission under IV Category with one of the following codes: • **CQ1** for the principal applicant; • **CQ2** for the spouse of principal applicant; or • **CQ3** for the unmarried child under 21 of principal applicant; and a • DHS stamp or notation on passport or I-94, showing date of entry. This includes DHS or CBP, or DHS or USCIS, temporary Form I-551 Alien Documentation Identification and Telecommunication (ADIT) stamp. **Or** ***I-551** with an **IV** code for category **CQ1**, **CQ2**, or **CQ3**. **Or** **I-765**, Employment Authorization Document (EAD), receipt notice with code C11. **Or** **I-766**, Employment Authorization Document (EAD), with code C11. **Note:** The entry date for an Afghan special immigrant must be Dec. 26, 2007, or later. The entry date for an Iraqi special immigrant must be Jan. 26, 2008, or later.	

*An I-551, Permanent Resident Card, does not always include the holder's signature.

Note: The category of aliens listed in Chart A are eligible for SNAP benefits from the date they adjust to any of the specific statuses listed in the chart. For example, once an alien is granted asylee status, they are potentially eligible for SNAP benefits.

Use the following chart to determine the eligibility of these qualified aliens. Their eligibility is indefinite regardless of their date of entry into the U.S.

Chart B

If the alien was admitted as a …	and the USCIS document provided is an …	then the alien is eligible if the alien …
Parolee	• **I-94**, Arrival/Departure Record, showing admission for at least one year under INA	• has lawfully resided as a qualified immigrant in the U.S. for five years;

If the alien was admitted as a …	and the USCIS document provided is an …	then the alien is eligible if the alien …
	Section 212(d)(5) or Parolee; • **I-766**, Employment Authorization Document, annotated with A-4 or C-11;	• meets the SNAP definition of disability regardless of when the alien acquired a disability or when the alien entered the U.S.; • is currently under 18 regardless of when the alien entered the U.S.; or • is the spouse, unmarried surviving spouse or minor unmarried dependent child of an honorably discharged veteran or is an active duty military member.
Conditional Entrant	• **I-94**, Arrival/Departure Record, annotated with INA Section 203(a)(7); • **I-766**, Employment Authorization Document, annotated with A3;	• has lawfully resided as a qualified immigrant in the U.S. for five years; • meets the SNAP definition of disability regardless of when the alien acquired a disability or when the alien entered the U.S.; • is currently under 18 regardless of when the alien entered the U.S.; • is the spouse, unmarried surviving spouse or minor unmarried dependent child of an honorably discharged veteran or is an active duty; or • military member.

Use the chart below to determine eligibility for Legal Permanent Residents.

Chart C

If the qualified alien was admitted as a …	and the USCIS document provide is an …	then the alien is eligible if the alien …
Legal Permanent Resident	• **I-151**, Alien Registration Receipt Card (also known as a Green Card); • **I-551**, Resident Alien Card; and • ***I-551**, Permanent Resident Card (introduced Dec.1997)	• has lawfully resided as a qualified immigrant in the U.S. for five years; • meets the SNAP definition of disability (regardless of when the alien acquired a disability or when the alien entered the U.S); • is currently under 18 (regardless of when the alien entered the U.S.); • meets the 40 qualifying quarters requirement; • is an honorably discharged veteran who met the minimum active duty requirements for 24 months; ◦ or the period for which the person was called to active duty; • is an active duty military member; or • is the spouse, unmarried surviving spouse or minor dependent child of an honorably discharged veteran or active duty military member. **Note**: To qualify for SNAP as a surviving spouse of a deceased veteran or an active duty military member, the surviving spouse must not have remarried.

***An I-551, Permanent Resident Card, does not always include the holder's signature.

Chart D

If the alien was admitted as a …	and the USCIS document provided is an …	then the alien is …
Native American born in Canada who is entitled by treaty to reside in the U.S.	• ***I-551**, Permanent Resident Card, annotated with KIP – Kickapoo Indian Pass; • ***I-551** annotated with S13 – American Indian born in Canada.	eligible.

If the alien was admitted as a …	and the USCIS document provided is an …	then the alien is …
	• A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada.	
Hmong or Highland Lao tribe member when the tribe assisted the U.S. Armed Forces during the Vietnam War, or their spouses, unmarried dependent children, and the unmarried widow(er)s of those who are deceased	• **I-94** or ***I-551**	eligible if the immigrant: • is from Laos, Vietnam or Cambodia; and • claims to be a member of a Hmong or Highland Laotian tribe.

*An I-551, Permanent Resident Card, does not always include the holder's signature.

Related Policy

Verifying 40 "Qualifying Quarters," A-354
Verifying Alien's USCIS Documents, A-355
Definition of Disability, B-432

A-342 TANF and Medical Programs Alien Status Eligibility Charts

Revision 25-1; Effective Jan. 1, 2025

Use the following chart to determine eligibility for qualified aliens admitted into the U.S. before Aug. 22, 1996.

Chart A

If the qualified alien was admitted as a/an	and the USCIS document is a/an	then the alien is
Refugee	• ***I-551**, Permanent Resident Card, annotated with R8-6, RE1 thru RE9 • **I94**, Arrival/Departure Record, annotated with INA Section 207 or Refugee • **I-766**, Employment Authorization Document, annotated with Code **A-3**	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse, including unmarried surviving spouse, of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada; ◦ member of a federally recognized Indian tribe; ◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully lived in the U.S. on or before Aug. 22, 1996; or ◦ LPR credited with 40 qualifying quarters of Social Security coverage.

If the qualified alien was admitted as a/an	and the USCIS document is a/an	then the alien is
		• **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Asylee	• ***I-551**, Permanent Resident Card, annotated with AS-6 thru AS-9 • **I-94**, Arrival/Departure Record, annotated with INA Section 208 or Asylee • **I-766**, Employment Authorization Document, annotated with Code A5 • USCIS Asylum Office letter • Order from an immigration judge granting asylum	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse, including unmarried surviving spouse, of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada; ◦ member of a federally recognized Indian tribe; ◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully lived in the U.S. on or before Aug. 22, 1996; or ◦ LPR credited with 40 qualifying quarters of Social Security coverage. • **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Deportation Withheld	• **I-94**, Arrival/Departure Record, annotated with INA Section 243(h) or 241(b)(3) • **I-766**, Employment Authorization Document, annotated with code A10 • Order from an immigration judge showing deportation withheld under INA Section 243(h) or Section 241(b)(3). Consider the date of entry as the date the status was assigned.	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse, including unmarried surviving spouse, of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada; ◦ member of a federally recognized Indian tribe; ◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully resided in the U.S. on or before Aug. 22, 1996; or

If the qualified alien was admitted as a/an	and the USCIS document is a/an	then the alien is
		◦ LPR credited with 40 qualifying quarters of Social Security coverage. • **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Cuban or Haitian Entrant	• ***I-551**, Permanent Resident Card, annotated with R8-6, CH-6, CU-6 or CU-7 • **I-94**, Arrival/Departure Record, annotated with INA Section 212(d)(5) or Cuban or Haitian Entrant • **I-94**, Arrival/Departure Record, annotated with INA Section 240 Pending Hearing – Cuban granted parole for one year • **I-94**, Arrival/Departure Record, annotated with Public Interest Parolee	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse, including unmarried surviving spouse, of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada; ◦ member of a federally recognized Indian tribe; ◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully lived in the U.S. on or before Aug. 22, 1996; or ◦ LPR credited with 40 qualifying quarters of Social Security coverage. • **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Haitian Orphan	• **I-94**, Arrival/Departure Record, showing person has humanitarian parole status admitted on or after Jan. 12, 2010 • **Immigrant visa** showing the person was lawfully admitted for permanent residence • ***I-551**, Permanent Resident Card, annotated with status code **CH-5**	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse including unmarried surviving spouse of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada; ◦ member of a federally recognized Indian tribe; ◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully resided in the U.S.

If the qualified alien was admitted as a/an	and the USCIS document is a/an	then the alien is
		on or before Aug. 22, 1996; or ◦ LPR credited with 40 qualifying quarters of Social Security coverage. • **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Amerasian	• ***I-551**, Permanent Resident Card, annotated with one of the following status codes: **AM-1, AM-2, AM-3, AM-6, AM-7** or **AM-8**	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse, including unmarried surviving spouse, of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada; ◦ member of a federally recognized Indian tribe; ◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully lived in the U.S. on or before Aug. 22, 1996; or ◦ LPR credited with 40 qualifying quarters of Social Security coverage. • **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Parolee	• **I-94**, Arrival/Departure Record, annotated with INA Section 212(d)(5) showing admission for at least one year **Note**: This does not include Cuban or Haitian entrants.	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse, including unmarried surviving spouse, of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada; ◦ member of a federally recognized Indian tribe;

If the qualified alien was admitted as a/an	and the USCIS document is a/an	then the alien is
		◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully lived in the U.S. on or before Aug. 22, 1996; or ◦ LPR credited with 40 qualifying quarters of Social Security coverage. • **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Conditional Entrant	• **I-94**, Arrival/Departure Record, annotated with INA Section 203(a)(7) • **I-766**, Employment Authorization Document, annotated with status code A-3	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse, including unmarried surviving spouse, of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada; ◦ member of a federally recognized Indian tribe; ◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully lived in the U.S. on or before Aug. 22, 1996; or ◦ LPR credited with 40 qualifying quarters of Social Security coverage. • **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Legal Permanent Resident	• **I-151**, Alien Registration Receipt Card – commonly referred to as Green Card • ***I-551**, Resident Alien Card • ***I-551**, Permanent Resident Card	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse, including unmarried surviving spouse, of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada;

If the qualified alien was admitted as a/an	and the USCIS document is a/an	then the alien is
		◦ member of a federally recognized Indian tribe; ◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully lived in the U.S. on or before Aug. 22, 1996; or ◦ LPR credited with 40 qualifying quarters of Social Security coverage. • **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Native American born in Canada who is entitled by treaty to reside in the U.S.	• ***I-551** annotated with KIC – Kickapoo Indian Citizen • ***I-551** annotated with KIP – Kickapoo Indian Pass • ***I-551** annotated with S13 – American Indian born in Canada • **Letter** — A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada	• eligible for TANF; and • eligible for Medicaid if the alien meets one of the following requirements: ◦ honorably discharged veteran or active duty member of the U.S. armed forces; ◦ spouse, including unmarried surviving spouse, of honorably discharged veterans or active duty members; ◦ dependent child of honorably discharged veteran or active duty member; ◦ American Indian born in Canada; ◦ member of a federally recognized Indian tribe; ◦ received SSI, Medicaid or both on Aug. 22, 1996 and lawfully lived in the U.S. on or before Aug. 22, 1996; or ◦ LPR credited with 40 qualifying quarters of Social Security coverage. • **Note**: Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.
Compact of Free Association (COFA) citizens residing in the U.S. • **Republic of the Marshall Islands (RMI);** • **Federated States of Micronesia (FSM); and Republic of Palau (PAL).**	**I-94** or **I-766** annotated with the following Class of Admission (COA) Codes: • **CFA/RMI** – Citizen of Republic of the Marshall Islands (RMI) due to the Compact of Free Association • **CFA/FSM** – Citizen of the Federated States of Micronesia (FSM) • **CFA/PAL** – Citizen of the Republic of Palau **I-766,** Employment Authorization Document (EAD), annotated with the following Category Code: • **A-08** Citizen of the Marshall Islands, Micronesia or Palau admitted as a nonimmigrant	• Eligible for Medicaid

If the qualified alien was admitted as a/an	and the USCIS document is a/an	then the alien is
	An unexpired **passport** annotated with one of the following: • **CFA/RMI** – Citizen of Republic of the Marshall Islands (RMI) due to the Compact of Free Association • **CFA/FSM** – Citizen of the Federated States of Micronesia (FSM) • **CFA/PAL** – Citizen of the Republic of Palau	

*An I-551, Permanent Resident Card, does not always include the holder's signature.

Note: An I-766 with the statement **Serves as I-512 Advance Parole** is a Combination Employment Authorization and Advance Parole Card, known as a combo card. The combo card serves as both an EAD and an Advance Parole Document. The combo card is only available for certain applicants who have a pending Form I-485, Application to Register Permanent Residence or Adjust Status. This document may also include the letter P, such as C09P. Disregard the letter P.

Use the following chart to determine eligibility for TANF and Medicaid for qualified aliens admitted into the U.S. on or after Aug. 22, 1996.

Chart B

If the qualified alien was admitted as a/an	and the USCIS document provided is a/an	then the alien is
Refugee	• ***I-551**, Permanent Resident Card, annotated with R8-6, RE1 thru RE9 • **I-94**, Arrival/Departure Record, annotated with INA Section 207 or Refugee • An original certification letter from the Office of Refugee Resettlement (ORR) • **I-766**, Employment Authorization Document, annotated with Code A-3	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid, including Parents and Caretaker Relatives Medicaid, for the first seven years after the legal date of entry. **Notes**: • Qualified aliens keep this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Asylee	• ***I-551**, Permanent Resident Card, annotated with R8-6, AS-6 thru AS-9 • **I-94**, Arrival/Departure Record, annotated with INA Section 208 or Asylee • **I-766**, Employment Authorization Document, annotated with Code A-5 • USCIS letter from Asylum office • Order from an immigration judge granting asylum	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid, including Parents and Caretaker Relatives Medicaid, for the first seven years after the legal date of entry. **Notes**:

If the qualified alien was admitted as a/an	and the USCIS document provided is a/an	then the alien is
		• Qualified aliens retain this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Deportation Withheld	• **I-94**, Arrival/Departure Record, annotated with INA Section 243(h) or Section 241(h)(3) • **I-766**, Employment Authorization Document, annotated with Code A-10 • Order from an immigration judge showing deportation withheld under INA Section 243(h) or Section 241(b)(3). Consider the date of entry as the date the status was assigned.	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid, including Parents and Caretaker Relatives Medicaid, for the first seven years after the legal date of entry. **Notes**: • Qualified aliens keep this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Cuban or Haitian Entrant	• ***I-551**, Permanent Resident Card, annotated with R8-6, CH-6, CU-6 or CU-7 • **I-94**, Arrival/Departure Record, annotated with INA Section 212(d)(5) or Cuban or Haitian Entrant **I-94**, Arrival/Departure Record, annotated with INA Section 240, Pending Hearing – Cuban, granted parole for one year • **I-94**, Arrival/Departure Record, annotated as Public Interest Parole • **I-220A**,Order of Release on Recognizance • **I-862**, Notice to Appear	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid, including Parents and Caretaker Relatives Medicaid, for the first seven years after the legal date of entry. **Notes**: • Qualified aliens keep this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Haitian Orphan	• **I-94**, Arrival/Departure Record, indicating person has humanitarian parole status admitted on after Jan. 12, 2010 • **Immigrant visa** indicating the person was lawfully admitted for permanent	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid, including

If the qualified alien was admitted as a/an	and the USCIS document provided is a/an	then the alien is
	residence • ***I-551**, Permanent Resident Card, annotated with Status Code **CH-6**	Parents and Caretaker Relatives Medicaid, for the first seven years after the legal date of entry. **Notes**: • Qualified aliens keep this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Amerasian	***I-551**, Permanent Resident Card, annotated with one of the following status codes: **AM-1, AM-2, AM-3, AM-6, AM-7 or AM-8**	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid, including Parents and Caretaker Relatives Medicaid, for the first seven years after the legal date of entry. **Notes**: • Qualified aliens retain this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Afghan or Iraqi Special Immigrant	**Passport** with a Machine Readable Immigrant Visa (MRIV) or with a stamp noting that the person has been admitted under a special immigrant visa (IV) category with one of the following codes: • **SI-1 or SQ-1** for the principal applicant; • **SI-2 or SQ-2** for the spouse of principal applicant; • **SI-3 or SQ-3** for the unmarried child under 21 of principal applicant; and a • DHS stamp or notation on passport includes DHS or CBP, or DHS or USCIS temporary Form *I-551 Alien Documentation Identification and Telecommunication (ADIT) stamp or **I-94**, showing date of entry. **or**	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid, including Parents and Caretaker Relatives Medicaid, for the first seven years after the legal date of entry. **Notes**: • Qualified aliens keep this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters

If the qualified alien was admitted as a/an	and the USCIS document provided is a/an	then the alien is
	***I-551** annotated with an **IV** code for category **SQ-1**, **SQ-2** or **SQ-3**. **or** **I-765**, Employment Authorization Document (EAD), receipt notice with code **SQ1**, **SQ2**, **SQ3**, **SQ6**, **SQ7** or **SQ8**. **or** **I-766**, Employment Authorization Document (EAD), with code **SQ1**, **SQ2**, **SQ3**, **SQ6**, **SQ7** or **SQ8**. **For special immigrants who are Special Immigrant Parolees (SI or SQ Parole):** **I-94** noting Special Immigrant Status (SQ or SI) Parole Section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006 **or** SQ4/SQ5 SI Parolee notation signed and dated by USCIS officer: •**SQ-4** for the principal applicant; •**SQ-5** for the spouse or unmarried child under 21 of principal applicant. **or** **I-765**, Employment Authorization Document (EAD), receipt notice with code C11. **or** **I-766**, Employment Authorization Document (EAD), with code C11. **For special immigrants who are adjusting their status to LPR status in the U.S.:** ***I-551** annotated with one of the following status codes: • **SI-6 or SQ-6** for the principal applicant; • **SI-7 or SQ-7** for the spouse of principal applicant; or • **SI-8 or SQ-8** for the unmarried child under 21 of principal applicant. Special immigrants also may demonstrate nationality with an Afghan or Iraqi passport. **For special immigrants who are conditional permanent residents (SI CPRs) adjusting their status to LPR status in the U.S.:** **Passport** with a MRIV, or DHS or CBP stamp noting admission under **IV** Category with one of the following codes: • **CQ** for the principal applicant; • **CQ2** for the spouse of principal applicant; or • **CQ3** for the unmarried child under 21 of principal applicant; and • a DHS stamp or notation on passport includes DHS or CBP or DHS or	of Social Security coverage.

If the qualified alien was admitted as a/an	and the USCIS document provided is a/an	then the alien is
	USCIS temporary Form *I-551 Alien Documentation Identification and Telecommunication (ADIT) stamp or **I-94**, showing date of entry. **or** ***I-551** annotated with an **IV** code for category **CQ1, CQ2 or CQ3.** **or** **I-765**, Employment Authorization Document (EAD), receipt notice with code C11. **or** **I-766**, Employment Authorization Document (EAD), with code C11. **Note:** The entry date for an Afghan special immigrant must be Dec. 26, 2007, or later. The entry date for an Iraqi special immigrant must be Jan. 26, 2008, or later.	
Victim of Severe Trafficking	• Derivative T Visa annotated with **T-1** • Derivative T Visa annotated with **T-2, T-3, T-4, or T-5,** family members of a victim of severe trafficking	eligible up to four years from date of entry or until the law enforcement extension expires. **Note**: Qualified aliens keep this eligibility even if they have adjusted to LPR status.
Native American born in Canada who is entitled by treaty to reside in the U.S.	• ***I-551** annotated with KIC – Kickapoo Indian Citizen • ***I-551** annotated with KIP – Kickapoo Indian Pass • ***I-551** annotated with S13 – American Indian born in Canada • **Letter** — A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada	eligible.
Member of a federally recognized Indian tribe	**Letter** — A letter or other tribal document that verifies membership of a federally recognized Indian tribe as defined in United States Code (U.S.C.), Title 25, Chapter 14, Subchapter II, Section 450b(e)	eligible.
Compact of Free Association (COFA) citizens residing in the U.S. • **Republic of the Marshall Islands (RMI);** • **Federated States of Micronesia (FSM); and Republic of Palau (PAL).**	**I-94 or I-766** annotated with the following Class of Admission (COA) Codes: • **CFA/RMI** – Citizen of Republic of the Marshall Islands (RMI) due to the Compact of Free Association • **CFA/FSM** – Citizen of the Federated States of Micronesia (FSM) • **CFA/PAL** – Citizen of the Republic of Palau **I-766** Employment Authorization Document (EAD), annotated with the following Category Code:	• Eligible for Medicaid

If the qualified alien was admitted as a/an	and the USCIS document provided is a/an	then the alien is
	• **A-08** Citizen of the Marshall Islands, Micronesia or Palau admitted as a nonimmigrant An unexpired passport annotated with one of the following: • **CFA/RMI** – Citizen of Republic of the Marshall Islands (RMI) due to the Compact of Free Association • **CFA/FSM** – Citizen of the Federated States of Micronesia (FSM) • **CFA/PAL** – Citizen of the Republic of Palau	

*An I-551, Permanent Resident Card, does not always include the holder's signature.

Notes:

- Click on the federal regulatory language hyperlink for a list of the Indian tribes recognized by the United States Bureau of Indian Affairs.
- An I-766 with the statement, **Serves as I-512 Advance Parole**, is a Combination Employment Authorization and Advance Parole Card, known as a combo card. The combo card serves as both an EAD and an Advance Parole Document. The combo card is only available for certain applicants who have a pending Form I-485, Application to Register Permanent Residence or Adjust Status. This document may also include the letter P, such as C09P. Disregard the letter P.

Use the following chart to determine eligibility:

- for all LPRs and Parolees applying for TANF; and
- adult LPRs and Parolees applying for Medicaid who were admitted into the U.S. on or after Aug. 22, 1996.

Chart C

If the qualified alien was admitted as a/an	and the USCIS document provided is a/an	then the alien is
Legal Permanent Resident	• **I-151**, Alien Registration Receipt Card – commonly referred to as Green Card • ***I-551**, Resident Alien Card • ***I-551**, Permanent Resident Card **Notes**: • Any status code that appears on the *I-551, Permanent Resident Card, is acceptable. • USCIS did not issue I-151s after 1978; therefore, any alien admitted after 1978 will have an *I-551. • If the LPR loses the *I-551, the LPR may present either an I-94 or a passport with the following annotation: Processed for *I-551, Temporary Evidence of Lawful Admission for	not eligible. **Note**: A qualified alien keeps the refugee eligibility period even if they have adjusted to LPR status. **Exceptions**: An LPR meets the eligibility requirements if the person: • is a naturalized citizen; • is an honorably discharged veteran or active duty military member; • is a spouse, unmarried surviving spouse or minor unmarried child of an honorably discharged veteran or active duty military member. • entered the U.S. before Aug. 22, 1996, and remained continuously present in the U.S. since at least Aug. 21, 1996, until obtaining qualifying immigrant status; and • meets the 40 qualifying quarters of Social Security coverage requirement. **Note**: Aliens who entered the country without proper documents, as well as

If the qualified alien was admitted as a/an	and the USCIS document provided is a/an	then the alien is
	Permanent Residence, valid until _____, Employment Authorized.	those who overstayed their visa, are treated the same as those who entered and remained in the country with valid immigration documents. Any single absence from the U.S. of more than 30 days or a combined absence of more than 90 days is considered interrupted continuous presence.; • received SSI, Medicaid or both on Aug. 22, 1996, and lawfully resided in the U.S. on or before Aug. 22, 1996; • entered the U.S. with a status described in Chart B and meets those eligibility criteria, or meets the criteria for Battered Aliens; or • meets the 40 qualifying quarters requirements and five years have passed since the alien's legal date of entry. **Note**: To qualify for TANF/MP as a surviving spouse of a deceased veteran or an active duty military member, the surviving spouse must not have remarried.
Parolee	• **I-94**, Arrival/Departure Record, annotated with INA Section 212(d)(5) showing admission for at least one year. **Note:** • This does not include Cuban or Haitian entrants.	not eligible. **Exceptions:** A Parolee meets the eligibility requirements if the person: • is a naturalized citizen; • is an honorably discharged veteran or active duty military member; • is a spouse, unmarried surviving spouse or minor unmarried child of an honorably discharged veteran or active duty military member. **Note:** To qualify for TANF/MP as a surviving spouse of a deceased veteran or an active duty military member, the surviving spouse must not have remarried.; • entered the U.S. before Aug. 22, 1996 and remained continuously present in the U.S. since at least Aug. 21, 1996, until obtaining qualifying immigrant status. **Note:** Aliens who entered the country without proper documents, as well as those who overstayed their visa, are treated the same as those who entered and remained in the country with valid immigration documents. Any single absence from the U.S. of more than 30 days or a combined absence of more than 90 days is considered interrupted continuous presence; • received SSI, Medicaid or both on Aug. 22, 1996, and lawfully resided in the U.S. on or before Aug. 22, 1996; • entered the U.S. with a status described in Chart B and meets those eligibility criteria, or meets the criteria for Battered Aliens; or • has lived in the U.S. for five years since their legal date of entry.

If the qualified alien was admitted as a/an	and the USCIS document provided is a/an	then the alien is
Native American born in Canada who is entitled by treaty to reside in the U.S.	• ***I-551** annotated with KIC – Kickapoo Indian Citizen • ***I-551** annotated with KIP – Kickapoo Indian Pass • ***I-551** annotated with S13 – American Indian born in Canada • **Letter** — A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada.	eligible.
Member of a federally recognized Indian tribe	**Letter** — A letter or other tribal document that verifies membership of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e)	eligible.

*An I-551, Permanent Resident Card, does not always include the holder's signature.

Notes:

- If the alien is ineligible for Medicaid because of citizenship or alien status, determine the alien's eligibility for Emergency Medicaid.
- The federal regulatory language (external link) provides a list of the Indian tribes recognized by the United States Bureau of Indian Affairs.
- An I-766 with the statement Serves as I-512 Advance Parole, is a Combination Employment Authorization and Advance Parole Card, known as a combo card. The combo card serves as both an EAD and an Advance Parole Document. The combo card is only available for certain applicants with a pending Form I-485, Application to Register Permanent Residence or Adjust Status. This document may also include the letter P, such as C09P. Disregard the letter P.

Medical Programs

Certain other qualified immigrant and non-immigrant children 18 and under who are lawfully living in the U.S. may qualify for Medicaid regardless of their date of entry.

Use the following chart to determine eligibility for qualified immigrant and non-immigrant children.

Note: The documents, immigration statuses, or both listed in the chart are not all inclusive. **All lawfully residing children with a valid immigration status are eligible. Follow policy clearance request procedures for questions about documents or immigration statuses not listed in this chart.**

Exceptions:

- Healthy Texas Women (HTW) recipients who turn 19 during their certification period will continue to receive HTW until their next redetermination. Review the HTW recipient's alien status at redetermination.
- Medicaid for Transitioning Foster Care Youth (MTFCY) recipients qualify through the month of their 21st birthday.
- Medicaid for Former Foster Care Children (FFCC) recipients qualify through the month of their 21st birthday.
- Medicaid for Breast and Cervical Cancer (MBCC) recipients who applied before their 19th birthday remain eligible for Medicaid through the duration of their cancer treatment or until they no longer meet all the other eligibility criteria, whichever is earlier.

Chart D

If the qualified immigrant and non-immigrant's USCIS document is a/an	then the qualified immigrant and non-immigrant is eligible if the annotation is
I-94	• INA Section 212(d)(5) showing admission for less than one year – Parolee • INA Section 203(a)(7) – Conditional Entrant

If the qualified immigrant and non-immigrant's USCIS document is a/an	then the qualified immigrant and non-immigrant is eligible if the annotation is
	Note: The Bureau of Customs and Border Protection (CBP) also notates the I-94 with the letters D/S. This stands for duration of status, meaning that the authorized length of stay is not limited.
I-797C, or USCIS referral notice, or hearing notice or order from an immigration judge	241(b)(3): • Convention Against Torture (CAT) – An alien who has been granted withholding of removal under CAT • Applicants for asylum or withholding of removal, including under CAT • Applicants for asylum or withholding of removal, including under CAT if under 14 who has had an application pending for at least 180 days
***I-551** **Note**: If the LPR loses the *I-551, the LPR may present either an I-94 or a passport with the following annotation: • Processed for I-551, Temporary Evidence of Lawful Admission for Permanent Residence, valid until _____, Employment Authorized.	Any status code that appears on the *I-551 is acceptable.
I-766	• CFA/RMI – Citizen of Republic of the Marshall Islands (RMI) due to the Compact of Free Association • CFA/FSM – Citizen of the Federated States of Micronesia (FSM) • CFA/PAL – Citizen of the Republic of Palau Aliens who have been granted employment authorization under 8 CFR 274a.12: • (c)(8) or C8 - Asylum applicant w/ pending asylum application who filed for asylum on or after Jan. 4, 1995 • (c)(9) or C9 – Applicant for adjustment to lawful permanent resident status • (c)(10) or C10 – Applicant for suspension of deportation or cancellation of removal • (c)(11) or C11 – Alien paroled into the U.S. in the public interest or temporarily for emergency reasons • (c)(14) or C14 – Alien currently in deferred action status • (c)(16) or C16 – Applicant for registry, resided in U.S. since before Jan. 1, 1972 • (c)(18) or C18 – Under order of supervision • (c)(20) – Applicant for special agricultural worker legalization (INA 210) • (c)(22) – Applicant for legalization under INA 245A • (c)(24) – Applicant for adjustment under the LIFE Act Legalization Program
I-797	• Alien currently in deferred action status • Action notice that identifies the alien as a self-petitioning battered alien

If the qualified immigrant and non-immigrant's USCIS document is a/an	then the qualified immigrant and non-immigrant is eligible if the annotation is
	• Special immigrant status under INA Section 101(a)(27)(J), the person will also have Form I-360
Visa	• A or G – FSM, RMI or Palauan diplomats • TPS – Person under temporary protected status under INA Section 244 Academic student under INA 101(a)(15)(F): • F-1 - Academic student • F-2 - Spouse or children of F-1 Exchange visitor under INA 101(a)(15)(J) • J-1 - Exchange visitor • J-2 - Spouse or children of J-1 Fiancé or fiancée of U.S. citizen as permitted under INA Section 101(a)(15)(K): • K-1 – Fiancé or fiancée • K-2 – Child of K-1 • K-3 – Spouse of U.S. citizen • K-4 – Child accompanying or following to join a K-3 alien Vocational student under INA 101(a)(15)(M) • M-1 - Vocational student • M-2 - Spouse or children of M-1 Special immigrant under INA Section 101(a)(15)(N): • N-8 – Parent of alien classified SK-3 "Special Immigrant" • N-9 – Child of N-8, SK-1, SK-2 or SK-4, "Special Immigrant" Religious worker under INA Section 101(a)(15)(R): • R-1 – Religious worker • R-2 – Spouse or children of R-1 Witness or informant as permitted under INA Section 101(a)(15)(S): • S-5 – Informant of criminal organization information • S-6 – Informant of terrorism information Victim of severe trafficking as permitted under INA Section (a)(15)(T): • Derivative T Visa annotated with T-1 • Derivative T Visa annotated with T-2, T-3, T-4 or T-5, family members of a victim of severe trafficking Victims of certain crimes – Battered aliens under 101(a)(15)(U): • U-1 – People who have suffered substantial physical or mental abuse as victims of criminal activity • U-2 – Spouse of U-1 • U-3 – Child of U-1

If the qualified immigrant and non-immigrant's USCIS document is a/an	then the qualified immigrant and non-immigrant is eligible if the annotation is
	• U-4 – Parent of U-1 if U-1 is under 21 • U-5 – Unmarried, under 18, sibling of U-1 People with a petition pending for three years or more, as permitted under INA Section 101(a)(15)(V): • V-1 – Spouse of an LPR who is the principal beneficiary of a family-based petition (Form I-130) that was filed before Dec. 21, 2000, and has been pending for at least three years • V-2 – Child of an LPR who is the principal beneficiary of a family-based visa petition (Form I-130) that was filed prior to Dec. 21, 2000, and has been pending for at least three years • V-3 – Derivative child of V-1 or V-2
USCIS letter	A person who is a spouse or child of a U.S. citizen, whose visa petition has been approved, and who has a pending application for adjustment of status described in 8 CFR INA Section 103.12(a)(4)
USCIS letter	Person under Deferred Enforced Departure per a decision made by the president
Letter	A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada
USCIS document	Family Unity beneficiaries per Section 301 of Pub. L. 101-649, as amended
USCIS document	An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. Section 1806(e)
USCIS document	A person who is lawfully present in American Samoa under the immigration laws of American Samoa

*An I-551, Permanent Resident Card, does not always include the holder's signature.

Note: An I-766 with the statement **Serves as I-512 Advance Parole**, is a Combination Employment Authorization and Advance Parole Card, known as a combo card. The combo card serves as both an EAD and an Advance Parole Document. The combo card is only available for certain applicants who have a pending Form I-485, Application to Register Permanent Residence or Adjust Status. This document may also include the letter P, such as C09P. Disregard the letter P.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Aliens living in the U.S. who do not meet the citizenship or immigration status requirements for Medical Programs may be eligible for Emergency Medicaid. These people include non-immigrants, undocumented aliens and certain legal permanent resident aliens.

Do not follow **SAVE** verification requirements for aliens applying for Emergency Medicaid.

Notes:

- To be eligible for Emergency Medicaid, a person must meet all other eligibility requirements.
- A person must be caring for a deprived child who meets citizenship or alien status requirements to be eligible for TA 31 as a caretaker or second parent.

Related Policy

How to Determine Eligibility, A-343
Verifying 40 "Qualifying Quarters," A-354
Verifying Alien's USCIS Documents, A-355

A-343 How to Determine Eligibility for Battered Aliens

Revision 18-1; Effective January 1, 2018

All Programs

Qualified aliens with a battered alien status do not need to be credited with 40 qualifying quarters of social security coverage, nor do they have a seven-year limited eligibility period.

SNAP

Advisors follow the steps in the chart below to determine whether an alien claiming battered status is potentially eligible for SNAP.

Step	Yes	No
1. Can the alien provide USCIS documentation* that identifies the alien as the self-petitioning spouse, ex-spouse or child of an abusive U.S. citizen or LPR? **Note:** Once the alien has provided proof that identifies him/her as a self-petitioning battered alien, the alien meets the definition of a "qualified alien," as defined in A-311.1, Definition of Qualified Immigrant.	Go to Step 2.	Stop — The alien is not eligible.
2. Can the battered alien meet **one** of the following conditions? The alien: ○ is under age 18; ○ is the spouse or minor unmarried dependent child of a person who is an active duty military member or an honorably discharged veteran; ○ has resided in the U.S. for 5 years from the date that the petition for battered status was approved and issued (**Note:** This is not the same as residing in the U.S. for 5 years as a qualified alien as defined in A-311.1); or ○ meets the SNAP definition of disability in B-432, Definition of Disability (regardless of when the alien acquired a disability or entered the U.S.).	Go to Step 3.	Stop — The alien is not eligible.
3. Is the battered alien living with the spouse/parent or other family member who abused or battered the alien?	Stop — The alien is not eligible.	Go to Step 4.
4. Did the alien: • enter the U.S. and acquire "qualified alien" status before Aug. 22, 1996; • reside in the U.S. before Aug. 22, 1996, adjust to "qualified alien" status on or after Aug. 22, 1996, and provide proof of continuous residence; • reside in the U.S. before Aug. 22, 1996, adjust to "qualified alien" status on or after Aug. 22, 1996, did not provide proof of continuous residence, but meets the five-year waiting period; or • enter the U.S. on or after Aug. 22, 1996, and meets the five-year waiting period?	The alien is eligible if the alien meets all other eligibility factors.	Stop — The alien is not eligible.

* Examples of acceptable USCIS documents include:

- I-551, Permanent Resident Card, annotated with one of the following status codes: **IB-1** through **IB-3** or **IB-6** through **IB-8**;
- I-797, Action Notice, that identifies the alien as a self-petitioning battered alien; or
- a final order from an immigration judge or the Board of Immigration Appeals granting suspension of deportation under Section 244(a)(3) of the Immigration and Nationality Act.

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Follow the steps in the chart below to determine if an alien claiming battered status is potentially eligible for TANF and/or Medical Programs.

Step	Yes	No
1. Can the alien provide USCIS documentation* that identifies the alien, the battered alien's child or the parent of a battered alien child as the self-petitioning spouse and/or child of an abusive U.S. citizen or LPR?	Go to Step 2.	Stop — The alien is not eligible.
2. Is the battered alien living with the spouse, ex-spouse, parent or other family member who abused or battered the alien?	Stop — The alien is not eligible.	Go to Step 3.
3. Did the alien: • enter the U.S. and acquire "qualified alien" status before Aug, 22, 1996? • reside in the U.S. before Aug. 22, adjust to "qualified alien" status on or after Aug. 22, 1996, and provide proof of continuous residence;	The alien is eligible if the alien meets all other eligibility factors.	Stop — The alien is not eligible.

Step	Yes	No
• reside in the U.S. before Aug.22, 1996, adjust to "qualified alien" status on or after Aug. 22, 1996, did not provide proof of continuous residence, but meets the five-year waiting period; or • enter the U.S. on or after Aug. 22, 1996 and meets the five-year waiting period?		

A-350, Verification Requirements

Body

Revision 13-2; Effective April 1, 2013

A-351 Verification of Citizenship

Revision 25-3; Effective July 1, 2025

All Programs

Items used to verify citizenship for Medical Programs, can also be used for SNAP and TANF.

If previously verified, do not reverify citizenship at application, redetermination or incomplete review unless questionable.

TANF

Verify citizenship for all household members applying for benefits and allow the household 10 days to provide verification. Document the type of verification provided.

If a household member applying for benefits refuses or fails without good cause to provide verification, the household member is disqualified until verification is provided.

SNAP

If questionable, verify U.S. citizenship for certified members. Disqualify any person with a questionable claim of U.S. citizenship until verification of citizenship is received.

Do not consider a person’s claim of U.S. citizenship questionable for SNAP solely if they fail to provide verification of citizenship for Medical Programs.

Medical Programs Except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Verify citizenship for all household members applying for benefits and allow the household a reasonable opportunity to provide verification.

Applicants requesting three months prior Medicaid coverage must provide citizenship verification before prior coverage can be provided.

Exception: Current Medicare and SSI recipients are exempt from the verification requirement. People who receive Retirement, Survivors and Disability Insurance (RSDI) based on disability, and who are in a 24-month waiting period to receive Medicare, are considered meeting the citizenship and identity verification requirement as Medicare recipients.

Related Policy

At Application, A-611
How to Verify Citizenship, A-351.4
Verification Sources, A-358
Budgeting for Members Disqualified for Citizenship, SNAP ABAWD Work Requirement or Noncompliance with Social Security Number Requirements, A-1362.3
Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits, A-1362.1

A-351.1 Reasonable Opportunity

Revision 20-4; Effective October 1, 2020

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, TP 45 and TA 85

Medicaid applicants who declare themselves to be U.S. citizens or declare to have an eligible alien status, but for whom verification of citizenship or alien status is unavailable, must be allowed a period of reasonable opportunity to provide verification of citizenship or alien status. Reasonable opportunity is defined as the 95-day period a person is allowed to provide this verification beginning the day the Form TF0001 is generated.

At application and when adding a person during a redetermination or change, if the person does not provide proof of citizenship or alien status and:

- **no other information is required** to determine eligibility, certify the person for Medicaid if all other eligibility requirements are met, send Form TF0001, Notice of Case Action, and provide a period of reasonable opportunity.
- **other information is required to determine eligibility**, request verification of the other information in addition to citizenship or alien status prior to providing a period of reasonable opportunity. If the other information is not returned, deny the person. If the person returns the other information but does not provide proof of citizenship or alien status, certify the person for Medicaid, send Form TF0001, and provide a period of reasonable opportunity.

Form TF0001 informs the person that verification of citizenship or alien status is required within 95 days and lists the names of each person who must provide citizenship verification. The period of reasonable opportunity begins the day Form TF0001 is generated.

All new applicants must be given a period of reasonable opportunity even if they have received a previous reasonable opportunity period.

The reasonable opportunity period may be triggered under the following conditions:

- the person cannot provide a Social Security number (SSN) needed to electronically verify citizenship with the Social Security Administration (SSA);
- the data available from an electronic data source and the person's declaration of citizenship or alien status are inconsistent; or
- electronic verification is unsuccessful, including agency efforts to resolve any inconsistencies, and additional documentation is still needed.

The day the reasonable opportunity period expires (the 95th day), TIERS generates an alert that creates a task. If verification of citizenship or alien status has not been provided, deny the person. 30 days advance notice of adverse action is provided to the household after informing them of the denial of ongoing benefits using Form TF0001, Notice of Case Action.

Related Policy

How to Take Adverse Action if Advance Notice Is Required, A-2343.1
Medicaid Suspension, B-520
Reasonable Opportunity after a Medicaid Suspension and Reinstatement, B-533
Reasonable Opportunity to Provide Citizenship and Alien Status Verification, D-441.1

A-351.2 Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship

Revision 15-4; Effective October 1, 2015

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

If an applicant has an SSN, use SOLQ or WTPY to verify citizenship.

The system attempts to verify citizenship using SOLQ through Electronic Data Sources (ELDS). If the SOLQ system is unresponsive or unavailable due to system failure, advisors must attempt to verify using WTPY.

If the SSN is verified, WTPY provides a response code for verification of citizenship. Advisors follow the steps in the chart below to determine the required advisor action for each response code. These response codes are only provided for Medicaid or CHIP requests.

If the WTPY response code is…	then staff must …
A SSN is verified, there is no indication of death, and the allegation of citizenship is consistent with SSA data,	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification drop-down menu. 2. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the citizenship verification drop-down menu.
B SSN is verified, there is no indication of death, and the allegation of citizenship is **NOT** consistent with SSA data,	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification drop-down menu.

If the WTPY response code is…	then staff must …
	2. See the process for **If unable to verify citizenship (Code B)** below.
C SSN is verified, there is indication of death, and the allegation of citizenship is consistent with SSA data,	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification drop-down menu. 2. Treat the death information as a change using policy in B-600, Changes.
D SSN is verified, there is indication of death, and the allegation of citizenship is **NOT** consistent with SSA data,	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification drop-down menu. 2. Treat the death information as a change using policy in B-600.

If unable to, Advisors should attempt to verify citizenship using the Birth Verification System (BVS).

1. If staff is unable to verify citizenship using BVS and additional information is required to determine eligibility, request the additional information and verification of citizenship and allow the individual at least 10 days to provide proof.
    - If the client does not return the additional information by the final due date, the advisor must deny the case for failure to provide required information.
    - If the client provides the additional information, but does not provide verification of citizenship, the advisor must allow the individual a period of reasonable opportunity (explained in A-351.1, Reasonable Opportunity) to provide the verification of citizenship.
2. If staff is unable to verify citizenship using BVS and no other information is required to determine eligibility, the advisor must allow the individual a period of reasonable opportunity to provide the verification without pending the EDG.

After allowing reasonable opportunity, if the recipient refuses or fails to provide proof, the advisor must deny the individual until proof of citizenship is provided.

SOLQ or WTPY responses may also include information on the receipt of SSI or RSDI. Advisors can find more information on the treatment of RSDI and SSI income explained in A-1324, Government Payments.

If the WTPY system is unresponsive or unavailable due to system failure, advisors must not deny or delay certification of Medicaid or CHIP coverage for failure to verify SSN or citizenship. Advisors must:

- enter the SSN as provided by the applicant into TIERS and allow the automated SSA interface to verify the SSN; and
- allow the individual a period of reasonable opportunity (explained in A-351.1) to provide the verification of citizenship.

A-351.3 Good Cause Determination

Revision 15-4; Effective October 1, 2015

TANF

Good cause exists when the Texas Health and Human Services Commission (HHSC) determines that circumstances beyond the individual's control prevent proving U.S. citizenship. The individual's statement that proof is delayed is acceptable.

At initial application and when adding a person, good cause is allowed until the next complete review. The individual must be advised that the verification must be provided by the next complete review or the individual will be disqualified.

A-351.3.1 Referrals to OIG

Revision 15-4; Effective October 1, 2015

TANF

Advisors must disqualify and refer an individual to the Office of Inspector General (OIG) if:

- the individual previously claimed to be a U.S. citizen but could not provide proof after allowing good cause; and
- other information indicates the individual's claim of citizenship is questionable.

A-351.4 How to Verify Citizenship

Revision 15-4; Effective October 1, 2015

All Programs

Advisors may refer to A-358.1, Citizenship, for common sources used to verify U.S. citizenship. For Medical Programs, advisors use the most reliable level of verification available from the sources listed as acceptable for Medical Programs. An affidavit is used only as a last resort when other verification is not available.

Advisors should explore derivative citizenship for any applicant born abroad to at least one U.S. citizen parent. If the applicant claims derivative citizenship, the applicant must provide a Certificate of Citizenship issued by the U.S. Citizenship and Immigration Services.

Related Policy

Reasonable Opportunity, A-351.1
Questionable Information, C-920
Providing Verification, C-930

TANF and SNAP

If the applicant cannot obtain the requested proof but can reasonably explain why it is not available, the advisor must obtain an affidavit signed by someone who knows the applicant's history. The advisor should advise signers that the affidavit is a sworn statement; signers can certify only those facts of which they have personal knowledge. The affidavit must state that the signer:

- is a U.S. citizen;
- knows that the applicant is a U.S. citizen; and
- may be fined, imprisoned or both if false information is given.

Through supervisory channels, the advisor must ask the regional attorney to make a determination if the applicant:

- does not have proof of citizenship and cannot obtain an affidavit as described above; or
- claims derivative citizenship and does not have a Certificate of Citizenship.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Verification requirements do not apply for undocumented aliens in the Emergency Medicaid certified group.

A-352 Verification of Alien Status

Revision 18-1; Effective January 1, 2018

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must verify alien status by:

- obtaining documentation of alien status, as explained in A-340, Qualified Alien Status Eligibility Charts; and
- accessing the USCIS SAVE VIS, as explained in A-355, Verifying Alien's USCIS Documents.

Advisors pend the EDG to allow an alien to update the alien's status with USCIS. An alien who does not have acceptable status is disqualified. If a certified alien’s document expires before the next redetermination, the alien’s immigration status must be re-verified following policies and procedures in A-313, Absence of Proof of Alien Status.

Advisors use the SAVE VIS:

- at application;
- when adding a new household member identified as an alien; or
- when the client’s USCIS document has expired.

Notes: If the alien’s USCIS document is expired and the SAVE response shows;

- The individual is a Lawful Permanent Resident - Employment Authorized and the Date Admitted is “Response is Indefinite,” the individual meets an alien status criteria. These individuals must not be disqualified.
- The individual's I-766, Employment Authorization Document, is not expired. These individuals must not be disqualified due to having an expired document.

SAVE does not contain information about victims of severe trafficking or nonimmigrant alien family members. At application, advisors must call the trafficking verification toll-free number at 866-401-5510 to confirm the validity of the certification letter or Derivative T Visa and to notify the Office of Refugee Resettlement of the benefits for which the individual is applying.

Medicaid and CHIP applicants or recipients who declare an alien status, but for whom verification of alien status is unavailable, must be allowed a period of reasonable opportunity to provide verification of alien status as explained in A-351.1, Reasonable Opportunity.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Do not follow the SAVE VIS verification procedures.

A-353 Verification of Military Connections

Revision 13-2; Effective April 1, 2013

A-353.1 Verification of Veteran Status

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must verify an individual's eligible veteran status by:

- a discharge certificate; or
- Form DD-214 or equivalent that shows the individual previously met active duty status in the armed forces.

Note: Discharge certificates that show character of discharge as anything but "honorable" are not acceptable. A character of discharge "Under Honorable Conditions" is **not** an "honorable" discharge for purposes of eligibility.

If the veteran does not have proof of discharge status, the veteran is referred to the Veteran's Administration to obtain verification.

A-353.2 Verification of Active Duty Military

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Individuals who claim they are currently on active duty in the military must provide a:

- current Military Identification Card, Form DD-2 (Active); or
- copy of their current military orders.

If the active duty military member does not provide proof of active duty status, the advisor must request other forms of proof.

A–353.3 Verification of a Spouse or Minor Unmarried Dependent Child of a Veteran or Active Duty Military Member or Unmarried Surviving Spouse of a Deceased Veteran or Active Duty Military Member

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Staff must verify whether an alien meets the eligibility requirements as:

- a spouse or minor unmarried dependent child of a veteran or active duty military member; or
- an unmarried surviving spouse of a deceased veteran or active duty military member.

To verify, advisors may use one of the following methods:

- view Form DD-214 for the discharged veteran;
- view the Military Identification Card (DD-2) that shows that the alien is married to or is a minor unmarried dependent child of a veteran or active duty military member; or
- refer the individual to the Veteran's Administration for verification.

A–354 Verifying 40 "Qualifying Quarters"

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must verify 40 qualifying quarters for LPR applicants or household additions that must meet this requirement. Advisors use the WTPY 40 Quarters Verification System to verify covered wages. Once verified, this information does not have to be reverified.

A–354.1 Response from Social Security Administration's (SSA) WTPY System

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

SSA does not complete the posting of covered earnings quarters for any one year until the following year (around August). **Example:** Quarters earned in 2012 may not be posted on the WTPY system until August 2013. These quarters are referred to as “Lag” quarters.

A response from SSA on the 40 quarters verification request takes approximately 48 hours to receive.

Advisors base the quarters of covered earnings on the calendar year’s **total** earnings. Each year, the amount of income needed to earn a quarter changes. State office advises staff of the change each year.

For 2012, an individual must earn $1,130 to earn one quarter. If the individual earned at least $4,520 for 2012 ($1,130 x 4), the client has four qualifying quarters for the year.

Note: Advisors must not allow credit for an incomplete or future quarter. **Example:** The quarter of July to September 2012 cannot be counted until October
2012, even though the individual earned enough income by March 2012 to receive credit for three quarters in 2012.

A–354.2 Non-Covered Wages

Revision 18-1; Effective January 1, 2018

All Programs Except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Non-covered wages are those earned by an individual whose employer was not required to pay into the Social Security system (such as certain city, federal, school or religious organization employees).

If the LPR cannot meet the 40 qualifying quarter requirement using covered earnings verified by the SSA, advisors must then obtain sufficient income verification from the individual's employer to determine the earned quarters for the period in question.

Use the chart below to determine if the individual has earned sufficient money to earn a quarter.

Year	Amount
1984	$390
1985	$410
1986	$440
1987	$460
1988	$470
1989	$500
1990	$520
1991	$540
1992	$570
1993	$590
1994	$620
1995	$630
1996	$640
1997	$670
1998	$700
1999	$740
2000	$780
2001	$830
2002	$870
2003	$890
2004	$900

Year	Amount
2005	$920
2006	$970
2007	$1,000
2008	$1,050
2009	$1,090
2010	$1,120
2011	$1,120
2012	$1,130
2013	$1,160
2014	$1,200
2015	$1,220
2016	$1,2060
2017	$1,300

Example: A former custodian worked for a school district from 2008 through 2011. The school district did not pay into the Social Security system. The advisor requested that the former custodian provide verification of their earnings for this particular period.* They brought a statement from the school district verifying their wages showing they earned $9,000 for 2008. Using the chart above, the income required to earn a quarter for 2008 is $1,050. This person can be credited with four quarters for 2008 ($1,050 x 4 = $4,200).

*If HHSC already has proof of income earned, advisors do not request that the individual provide additional verification.

Note: Credit for an incomplete or future quarter is not allowed.

A-354.3 Quarters Earned On or After January 1, 1997

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Federal law requires that quarters earned **on or after** January 1, 1997, cannot be credited if the person who earned the quarters received means-tested public benefits.

When determining the total amount of quarters earned by an LPR, advisors do not allow any quarters earned after January 1, 1997, if the person received TANF, SNAP, Medicaid or SSI benefits for the quarter. The WTPY system response does not reflect receipt of these benefits.

The SSA defines a quarter as a period of three calendar months:

- Quarter 1: January, February, March
- Quarter 2: April, May, June
- Quarter 3: July, August, September
- Quarter 4: October, November, December

A-354.4 Procedures for Verifying 40 Quarters

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must:

Step	Action
1	Ensure that the alien's LPR status has been verified.
2	Determine whose quarters of earnings have to be verified.
3	Obtain a consent of release before verifying quarters of coverage through the WTPY system or SSA. Use one of the following forms: **Note**: A consent form or signature is not required for spouses or parents who are deceased.

Step	Action

- Form SSA-3288, Social Security Administration Consent for Release of Information, must be signed by the:
  - LPR, if the LPR did not sign the application;
  - LPR's spouse, if the spouse did not sign the application; or
  - LPR's parent.
- Form SSA-513, Request for Quarters of Coverage History Based On Relationship, is completed when the LPR, spouse and/or parent:
  - refuses to sign Form SSA-3288; or
  - cannot be located.

Example: A husband, wife and their four children have applied for SNAP benefits. Both spouses and two of the children are LPRs (advisor has verified LPR status). The husband has worked in the U.S. for about six years, and the wife has worked about five years. The advisor must verify the quarters of earnings for both spouses.

Since the husband was the one who signed the application, he does not have to sign Form SSA-3288; however, a signed Form SSA-3288 is required for the wife. The advisor must also complete Form H1079, Qualifying Quarters of Social Security Earnings, for both spouses.

4

If the household signed Form SSA-3288, submit Form H1079 to the appropriate WTPY data entry staff with the following information:

- LPR's full name, as it appears on the Social Security card;
- LPR's date of birth; and
- LPR's correct Social Security number.

If the household signed Form SSA-513, send the completed form to the following address:

Social Security Administration
P.O. Box 17750
Baltimore, MD 21235-0001

5 If you are awaiting the verification from SSA's WTPY system (normally WTPY provides a response within 48 hours), issue Form H1020, Request for Information or Action, and pend the EDG.

If you sent Form SSA-513, disqualify the individual until you receive the response from SSA.

6 Use the WTPY or Form SSA-513 response to determine how many countable quarters are in the SSA records for the LPR, spouse and parent. Verify any recent earnings through the employer or case record if not yet posted on the WTPY system or not listed on Form SSA-513. Compute the quarters of covered earnings.

7 Disallow any quarters in which the wage earner received TANF, SNAP, Medicaid or SSI after January 1, 1997.

8

If the LPR:

- has 40 quarters, the LPR is eligible.
- does not have 40 quarters, the advisor sends Form TF0001, Notice of Case Action, to notify the household that the LPR is disqualified as an ineligible alien due to the lack of 40 allowable quarters of earnings.

9 If the individual disagrees with SSA's records for quarters of covered earnings, provide the individual with Form H1020. On Form H1020, explain that HHSC will certify the LPR if proof is provided that SSA was contacted to resolve the record of earnings. Provide the LPR copies of the WTPY response(s).

If the LPR needs to resolve a disagreement about a parent's or spouse's SSA record, advise the LPR that the spouse or parent must go to SSA to reconcile the individual's record. The LPR can resolve the SSA records for a deceased spouse or parent.

10

If the LPR contacts SSA to resolve the disagreement, SSA provides the individual with a document or Form SSA-7008, Request for the Correction of Earnings. The document or Form SSA-7008 verifies the action being taken to resolve the disagreement about the individual's SSA record. When the LPR provides the verification, submit the verification for imaging. Consider the LPR an eligible alien for TANF, SNAP and Medical Programs for one of the following time periods:

- for six consecutive months beginning the month the LPR contacted SSA, or
- less than six months if the LPR resolves the disagreement with SSA before the sixth month and the LPR does not have 40 allowable quarters of covered earnings.

Document this temporary eligibility period.

Step	Action
	Note: On a denied application, if the LPR provides the needed proof by the 60th day after the file date, reopen the application using the date the LPR provided the information as the file date.

A-355 Verifying Alien's USCIS Documents

Revision 20-2; Effective April 1, 2020

A-355.1 SAVE Program's Verification Information System (VIS)

Revision 20-2; Effective April 1, 2020

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

The Systematic Alien Verification for Entitlements (SAVE) program's Verification Information System (VIS) is a web-based application that provides alien status information using the applicants' alien registration number.

The SAVE System provides the following types of responses:

- Initial Verification Results: First Name, Last Name, Country, Date of Entry, Date of Birth, Class of Admission (COA) and System Response; and
- Additional Verification Results: Department of Homeland Security (DHS) Response, Expires On, Response Date and DHS Comments.

If the alien's USCIS document is expired and the SAVE response shows the individual is a Lawful Permanent Resident - Employment Authorized and the Date Admitted is "Response is indefinite," they meet alien status criteria.

Use the SAVE Verification Information System:

- at application;
- when adding a new household member identified as an alien; or
- if a person's alien documentation has expired.

Exceptions:

When SAVE does not contain information about victims of severe trafficking or non-alien family members, call the trafficking verification toll-free number at 866-401-5510 to:

- confirm the validity of the certification letter or Derivative T Visa; and
- notify the Office of Refugee Resettlement of the benefits for which the person is applying.

SAVE does not normally contain information about American Indians born outside of the U.S.

Related Policy

American Indians Born Outside the U.S., D-8420

A-355.2 How to Request an Initial Verification

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Supervisors complete and route Form 4743, Request for Applications and System Access, to the regional security officer for employees who need access to the SAVE system.

Advisors must follow these steps to access the SAVE system:

1. Open the VIS web site at https://save.uscis.gov/Web/vislogin.aspx?JS=YES.
2. Enter your User ID and password.
3. Select Initial Verification from the Case Administration menu.
4. Enter the document type that the applicant provided.
5. Enter the applicant's information as it appears on the document:
    - Alien Number — Do not include the letter A when entering the information in SAVE. If the A number has fewer than nine digits, add leading zeroes to make it a nine-digit number. USCIS# is used on the new I-551 cards instead of Alien Number.

- I-94 Identification Number — known as the admission number, consists of an 11-digit field. Enter leading zeroes if the I-94 number provided has less than 11 digits.
- Card Number — Card numbers for I-551 cards issued before November 2004 are at the bottom of the card toward the right-hand side. Card numbers for newer versions of I-551 are on the back of the card.
- Last name.
- First name.
- Date of birth.
- Document expiration date, if applicable.
- Required benefits — Select the benefit type from the Benefits List (SNAP, Medicaid, TANF).

6. Select Submit Initial Verification. The response appears in the Initial Verification Results section of the same page.
7. The screen displays one of the following messages:

- **Lawful Permanent Resident – Employment Authorized**;
- **Institute Additional Verification**; or
- **Temporary Resident/Temporary Employment Authorized**.

Note: If the response is **Temporary Resident/Temporary Employment Authorized**, the alien does not meet eligibility requirements.

8. Review the results and select Print Case Details.
9. Select Complete and Close Case to close the case (only if additional verification is not necessary). Once a case is closed, the user can view it for an additional 90 days.

A-355.3 How to Request Additional Verification – Online Process

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

To request additional verification:

1. In the Initial Verification Results section, select Request Additional Verification. The Enter Additional Verification Data section appears.
2. Edit the default information if necessary, enter required information, and include as much information as possible. Use the Special Comments box to enter additional information to the Immigration Status Verifier (ISV) staff.
3. Submit the request by selecting Submit Additional Verification. The response section appears indicating that the request is in process and will return the response within three working days.
4. To view the status of the case, select View Cases from the Case Administration menu. The Case Search page appears.
5. Enter the Case Search Criteria to search for cases based on the following case status:
    -
        - all open cases;
        - cases requiring action;
        - cases with additional verification responses;
        - cases in process; and
        - closed cases.

Select Display Case Summary List to open the Case Summary List page. The list displays the Case Status for cases that require action, cases in process, and closed cases. Click the Verification Number to view the Case Details. The user is able to print the case details, request additional verification, and close the case.

When the system is unable to verify the immigration status with the information provided by the user in the automated additional verification request, or the document appears counterfeit, altered, or expired, staff may use the manual process in A-355.4, How to Request Additional Verification – Manual Process.

A-355.4 Secondary Verification of Alien Immigration Status

Revision 20-2; Effective April 1, 2020

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36

If staff are unable to verify an alien's immigration status through primary verification procedures, use SAVE to request additional information from USCIS by requesting a Data Broker Combined Report through TIERS or the Data Broker Portal.

Once a request from USCIS is obtained for verification of immigration status, the information received must be processed. Staff receive one of the following responses from SAVE via the Combined Report in TIERS or in the Data Broker Portal:

- First level verification - initial verification request in TIERS.

- Second level verification - situations that require additional (secondary) verification in the Data Broker Portal.
- Third level verification - situations that require staff to upload documents for verification in the Data Broker Portal via SAVE.

For the first level verification, staff enter the information provided by the person into TIERS. Once the information is entered and SAVE is requested, SAVE will return an immediate response back indicating if the information entered was able to be verified with USCIS or if more information is needed.

If the information entered can be verified on the first level verification, staff will see the alien status, category code, and entry date. If the information entered is unable to be verified against USCIS records, then staff will have to proceed to second or third level verification responses to correctly verify the person's citizenship and alien status.

For second level verification and third level verification responses, Data Broker automatically requests additional verification from SAVE. Once obtained from SAVE, staff receive an email from the Data Broker vendor notifying them that the verification requested has been returned from SAVE.

For second level verification responses:

- The Data Broker vendor sends a subsequent email notifying staff that the verification has been returned from SAVE.
- Staff must then:
  - login to the Data Broker Portal to retrieve the information; and
  - update the Alien/Refugee Details page in TIERS accordingly.

For third level verification responses:

- Staff must:
  - upload the verification documents requested into the Data Broker Portal;
  - not mail the documents to USCIS; and
  - ensure only one PDF file containing all required verification documents is uploaded.
- The Data Broker vendor sends a subsequent email notifying staff SAVE has returned the verification.
  - staff must then login to the Data Broker Portal to retrieve the information; and
  - update the Alien/Refugee Details page in TIERS accordingly.

Note: SAVE only populates alien sponsor information into TIERS for the additional verification response. This is unlike initial verification that populates the response data for the applicant in the appropriate ELDS tables on the TIERS Alien/Refugee-Details page.

Related Policy

Filing an Overpayment Referral, B-770
Referrals for Intentional Program Violation (IPV), B-900

A-356 Verifying Alien's Date of Entry

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

The date on the alien's immigration document often represents the alien's first date of entry into the United States. In some instances, an alien may be present in the United States without a qualified status. The individual may then depart and then return to the U.S. as an LPR. For these aliens, the date on their immigration document reflects the date of entry with LPR status, rather than the alien's original date of entry.

Advisors use immigration documents to verify date of entry. Advisors must allow aliens with a USCIS document showing an entry date on or after August 22, 1996, who claim to have entered before that date, an opportunity to submit evidence of their claimed date of entry. This evidence may include pay stubs, a letter from an employer, or a lease or utility bill in the alien's name.

A-357 Verifying Alien's Continuous Presence

Revision 20-1; Effective January 1, 2020

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

The USCIS maintains a record of arrivals to and departures from the country for most legal entrants.

To verify continuous presence in the U.S., submit the Form G-845, Verification Request, and Form G-845S, Supplement Verification Request, electronically through the Data Broker system to the USCIS.

Other entrants, including aliens who entered the U.S. without USCIS documents, must provide documentary evidence showing proof of continuous presence, such as a letter from an employer, a series of pay stubs, or utility bills in the alien's name spanning the period in question.

Note: The alien does not have to remain continuously present in the U.S after obtaining qualified immigrant status.

Related Policy

How to Request Additional Verification – Online Process, A-355.3
How to Request Additional Verification – Manual Process, A-355.4

A-358 Verification Sources

Revision 13-2; Effective April 1, 2013

A-358.1 Citizenship

Revision 15-4; Effective October 1, 2015

TANF and SNAP Verification Sources:

- Birth Verification System automated process (for individuals born in Texas)
- Birth certificate (see **Note**)
- Naturalization papers (N-560 or N-561)
- Hospital record of birth
- Baptismal record with date and place of birth
- U.S. passport or U.S. passport card
- Military service papers
- Census records showing name, U.S. citizenship or U.S. place of birth, and date of birth or age
- Voter registration card (SNAP only)
- Local, state or federal records showing birthplace in the U.S.
- Regional attorney
- Civil service employment by the U.S. government
- American Indian Card
- Report of birth abroad (FS-240)
- Certificate of birth (FS-545 or DS-1350)

Alternate Sources

- Family Bible records
- Affidavit from U.S. citizen

Note: Individuals born in Puerto Rico must provide a birth certificate issued on or after July 1, 2010, unless previously certified using a birth certificate issued before July 1, 2010. See C-932, Advisor Responsibility for Verifying Information, for information regarding assisting an individual in obtaining birth verification from Puerto Rico.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Citizenship and Identity Verification

Verification sources are divided into two levels: Level 1 and Level 2. Level 1 sources establish both citizenship and identity. Level 2 sources establish citizenship only.

Level 1: Verifies Citizenship and Identity

SOLQ/WTPY
U.S. passport
Certificate of Naturalization (DHS Forms N-550 or N-570)
Certificate of U.S. Citizenship (DHS Forms N-560 or N-561)
State Data Exchange (SDX) for denied SSI recipients when the denial reason is for any reason other than citizenship
Evidence of membership or enrollment in a federally recognized tribe
SOLQ/WTPY and documentation on reason for Medicare denial
Inquiry reflecting a current or denied TP 45 Medicaid EDG
CHIP-P inquiry reflecting a current or denied CHIP-P case for the child

Level 2: Verifies Citizenship Only

If using a source from Level 2, the individual must also provide an additional source from the Medicaid and CHIP identity verification sources. The same source that was used to verify citizenship cannot be used to verify identity. Identify verification

Level 2: Verifies Citizenship Only

from A-621, Verification Sources, is required.

A U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after January 13, 1941)*, Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands (after November 4, 1986)*

BVS inquiry

Report of Birth Abroad of a U.S. Citizen (FS-240)

Certification of Birth Abroad (FS 545 or DS-1350)

U.S. Citizen Identification Card (Form I-179 or I-197)

Northern Mariana Identification Card (I-873)

Final adoption decree showing the child's name and U.S. place of birth

Evidence of U.S. civil service employment before June 1, 1976

U.S. military record showing a U.S. place of birth (Example: DD-214)

SAVE for naturalized citizens

If a child has not yet received a Certificate of Citizenship, N-560 or N-561, evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000, which includes:

- proof that at least one parent of the child is a U.S. citizen, by birth or naturalization;
- proof that the child is under age 18;
- proof that the child is residing in the U.S. in the legal and physical custody of the U.S. citizen parent;
- I-551, Permanent Resident Card; and
- I-551 with annotation of IR-3 or IR-4, if an adopted child.

Hospital record of birth showing a U.S. place of birth

Life, health, or other insurance record showing a U.S. place of birth

Religious record of birth recorded in the U.S. or its territories within three months of birth, which indicates a U.S. place of birth, showing either the date of birth or the individual's age at the time the record was made

Early school record (preschool or day care) showing a U.S. place of birth

Federal or state census record showing U.S. citizenship or a U.S. place of birth

Institutional admission papers from a nursing facility, skilled care facility or other institution showing a U.S. place of birth

Medical (clinic, doctor, or hospital) record, excluding an immunization record, showing a U.S. place of birth

An affidavit signed by another individual who can reasonably declare to the applicant's citizenship, regardless of blood relationship to the individual and under penalty of perjury, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized. Use only as a last resort when other evidence is not available.

* Individuals born in Puerto Rico must provide a birth certificate issued on or after July 1, 2010, unless certified previously using a birth certificate issued before July 1, 2010. C-932, Advisor Responsibility for Verifying Information, includes information regarding assisting an individual in obtaining birth verification from Puerto Rico.

American Indian/Alaska Natives (AI/AN)

Individuals can self-declare AI/AN status. Form H1205, Texas Streamlined Application, and Form H1010, Texas Works Application for Assistance — Your Texas Benefits, include a general question asking whether anyone in the household is an American Indian, Alaska Native, or member of a federally recognized tribe. In some instances, **Yes** may be selected on the application for this question, but information is not provided by the applicant in Appendix B, American Indian or Alaska Native Family Member (AI/AN), identifying the member of the household composition for Medical Programs to whom the status applies. If the name of the individual claiming AI/AN status is not provided, AI/AN status is considered not verified.

Related Policy

Providing Verification, C-930
Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship, A-351.2

A-358.2 Alien Status

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

- Form I-94, I-151, I-551, I-688B (with special annotations), I-766 (with special annotations), or other valid USCIS records
- Contact with USCIS

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Alien Entry Date

- Immigration document
- Contact with the USCIS
- Pay stubs
- Letter from employer
- Lease or utility bill in the alien's name
- School records
- Other document indicating entry date

Alien's Continuous Presence

- Contact with the USCIS
- Letter from employer
- Pay stubs or utility bills in the alien's name spanning the time period in question
- School records
- Other documents spanning the time period in question

A-360, Documentation Requirements

Body

Revision 15-4; Effective October1, 2015

All Programs

Advisors must document the:

- alien's status and how you verified it;
- USCIS document's expiration date if any;
- basis of alien's eligibility or ineligibility; and
- temporary eligibility period for the alien, described in A-354.4, Procedures for Verifying 40 Quarters, if applicable.

Advisors must document the verification number from the SAVE inquiry in case comments.

Related Policy

Documentation, C-940

SNAP

Advisors must document the proof of citizenship, if questionable.

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must document proof of citizenship.

Advisors must document the alien's:

- date of entry; and
- continuous presence, if necessary to establish eligibility.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

When using a verification source from Level 2, the advisor must document the reason Level 1 was not used.

Copies of the document used to verify citizenship must be legible and non-questionable.

Related Policy

The Texas Works Documentation Guide

A-400, Social Security Number

A-410, General Policy

Body

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

All applicants must provide a Social Security number (SSN) or apply for one through the Social Security Administration (SSA) before certification, unless they meet one of the criteria in this section.

Exception: Undocumented aliens are not required to apply for an SSN.

Non-applicants are not required to provide an SSN or proof of an application for an SSN. When non-applicants provide an SSN, advisors may attempt to verify the SSN using the procedures explained in A-440, Verification Requirements. If verification is not available through electronic data sources, verification of the non-applicant's SSN must not be requested from the applicant.

SNAP

Children age six months or younger are not required to provide proof of an application for an SSN. Newborns may receive benefits with the household without providing proof of an application for an SSN for the later of:

- six months following the child's birth, or
- the next recertification/complete review.

Applicants eligible for expedited service may receive initial benefits without providing or applying for an SSN. Initial benefits can include the first two months if receiving a combined allotment.

Applicants who cannot provide required proof to apply for an SSN may receive the Supplemental Nutrition Assistance Program (SNAP) for each month they have good cause. Good cause exists when circumstances beyond the individual's control prevent the individual from securing proof required to obtain an SSN.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

Applicants do not need to provide an SSN if they meet any of the following good cause reasons:

- They are not eligible to receive an SSN;
- They do not have an SSN and may only be issued an SSN for a valid non-work reason; or
- They refuse to obtain an SSN because of a well-established religious objection. A well-established religious objection exists when the applicant:
  - is a member of a recognized religious sect or division of the sect; and
  - adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Undocumented aliens applying for Emergency Medicaid are not required to provide an SSN.

TP 45

SSN requirements do not apply to TP 45.

If a TP 45 child has an SSN, advisors enter the SSN at Application Registration or during Data Collection in the Individual Information page. If the child does not have an SSN, advisors may refer the parent or caretaker to the SSA to complete Form SS-5, Application for Social Security Number.

A—411 Determining Staff Action at Application

Revision 20-2; Effective April 1, 2020

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

If the applicant ...	then ...
• cannot provide an SSN;* • provides an SSN that the Texas Integrated Eligibility Redesign System (TIERS) will not accept as valid; or • provides Form SSA-5028, Receipt for Application for an SSN, that is more than 30 days old,	• refer the applicant to the local Social Security Administration (SSA) office using a separate Form H1106, Enumeration Referral, for each member needing a Social Security Number (SSN); and • pend the application until SSA returns Form H1106 verifying the applicant has completed the application process. **Exception:** Follow policy in A-410, General Policy, for the applicable exceptions, by program.
• provides Form SSA-5028 (not more than 30 days old); or • provides Form SSA-2853, Message From Social Security, that is not more than 180 days old,	• accept the form as proof that the applicant applied for an SSN; • tell the applicant to report the SSN when the applicant receives it; and • enter the SSN in the Eligibility Determination Group (EDG), when reported. **Note:** Follow policy in A-412, Action at TANF and Medical Program Redetermination — Forms SSA-5028 or SSA-2853, for action to take at the next periodic review for Temporary Assistance for Needy Families (TANF) or Medicaid recipients.
provides an SSN,	• enter the SSN at Application Registration or during Data Collection in the Individual Information page. • Run State Online Query (SOLQ) during Data Collection if it is not automatically invoked by TIERS. Follow policy in A-413, SSN Validation Through State Online Query (SOLQ), if SOLQ verifies the SSN with a SSN Verification Code of F or X or does not verify the SSN.
provides an SSN but indicates the name and/or date of birth on record with SSA is not correct,	• enter the SSN at Application Registration or during Data Collection in the Individual Information page; and • refer the applicant to the local SSA office to update the person's SSA file using Form H1106. Do not pend the application for SSA's response. **Exception:** If SOLQ verifies the SSN with the SSN Verification Code of F or X or does not verify the SSN, follow policy in A-413.
provides an SSN but wants a replacement for a lost card,	• enter the SSN at Application Registration or during Data Collection in the Individual Information page; and • refer the applicant to the local SSA office without Form H1106; and • inform applicants age 18 and older that replacement SSN cards can be requested online by visiting the SSA.

* If the applicant cannot provide an SSN because the applicant is a documented alien without work authorization, refer the applicant to the local SSA office using Form H1106.

Explain the following to applicants applying for an SSN:

- the type of proof they must take to SSA to obtain an SSN (see page 2 of Form H1106, Proofs You Need to Apply for a Social Security Number Card, for common types of proof);
- the referral procedure and the results of any delay;
- that SSA must conduct a face-to-face interview with a person age 18 or over applying for an original SSN; and
- that a person applying for someone else (including an adult applying for a child) must provide proof of that person's own identity in addition to proof needed for the SSN application.

When an applicant takes Form H1106 to the SSA office, SSA:

- determines whether the applicant is eligible for an SSN;
- submits Form SS-5, Application for a Social Security Card, for those eligible; and
- adds information to Form H1106 or provides another SSA receipt or letter verifying the applicant completed the SSN application process.

Follow policy in A-420, Failure to Comply, if the applicant does not return Form H1106 with entries made by SSA, or another receipt or letter, verifying that an application for an SSN was submitted for each applicant by the 30th day after the file date, or later, to allow at least 10 days.

SNAP

If the applicant cannot complete the SSN application process in a timely manner, explain the procedure for claiming good cause. If the applicant claims to have good cause for not complying in a timely manner, determine whether good cause applies. The application is not pended for SSA's response if good cause applies.

Related Policy

General Policy, A-410
Action at TANF and Medical Programs Redetermination, A-412
Social Security Number (SSN) Validation Through State Online Query (SOLQ), A-413
Failure to Comply, A-420

A—412 Action at TANF and Medical Program Redetermination — Forms SSA-5028 or SSA-2853

Revision 20-2; Effective April 1, 2020

TANF and Medical Programs, except TP 43, TP 44, TP 45 and TP 48

Provide the person with Form H1106, Enumeration Referral, at the next complete review when:

- Form SSA-5028 or SSA-2853 is accepted at application,
- the form is no longer current; and
- no SSN has been received.

Inform the applicant that the form must be returned within 60 days. Explain to the person the consequence of noncompliance.

The complete review must not be pended for the return of Form H1106. Set a special review for the end of the 60-day period. Follow procedures in A-420, Failure to Comply, for noncompliance if:

- Form H1106 is not returned by the deadline; and
- an SSN is not received.

If an SSN is provided at the next complete review, enter the SSN during Data Collection and run SOLQ if it is not automatically invoked by TIERS. Follow policy in A-413, Social Security Number (SSN) Validation Through State Online Query (SOLQ), if SOLQ

- verifies the SSN with a SSN Verification Code of F or X; or
- does not verify the SSN.

TP 43, TP 44 and TP 48

Follow the procedures above, but do not set a special review. Check for compliance at the next review.

Related Policy

Social Security Number (SSN) Validation, A-413
Failure to Comply, A-420

A—413 Social Security Number (SSN) Validation Through State Online Query (SOLQ)

Revision 23-1; Effective Jan. 1, 2023

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

A person’s SSN is verified when all the demographic information provided by the person matches the information available in SOLQ. When the information matches, TIERS will display the SSN as validated. If the SSN is not verified, TIERS will display in the SOLQ screen the reason why the SSN is not verified.

SSN Verified

A person’s SSN is verified when SOLQ provides one of the following SSN Verification Codes:

- F: SSN is verified, but last name does not match SSN (an indication that the person has changed their last name due to marriage, divorce or adoption);
- M, P, R and V: SSN is verified; or

- X: Data exists that the validated SSN belongs to a person who is deceased.

When a person's SSN is verified with SOLQ, but information given by the SSA shows that the person is deceased (code X) or that the name does not match (code F), the person's identity is questionable. Clear the discrepancy before disposing the case action. If the person does not provide the information needed to clear the discrepancy, either disqualify or deny the person using failure to comply policy. **Exception:** When processing expedited SNAP benefits or Medicaid for Pregnant Women, certify the person with a validated SSN with verification code F or X if unable to clear the discrepancy by viewing case documentation, or contacting the household by phone. Postpone verification needed to clear the discrepancy to meet expedited processing time frames.

Note: If a person with a SOLQ verified SSN requests to change their name, date of birth or gender, the person must first update their information through the Social Security Administration.

SSN Not Verified

If the person's SSN is not verified with SOLQ, review the information on the application and other supporting documents and update any information entered incorrectly. After making corrections, manually invoke SOLQ to re-run the verification process.

If the person's identity is not questionable and the SSN remains unverified after re-running the SOLQ verification process, try to contact the person by phone to clear the SSN discrepancy. If unable to clear the discrepancy by phone and:

- No other information is required to determine eligibility, certify the person if all other eligibility requirements are met.
- Other information is required to determine eligibility, include the request for information to clear the SSN discrepancy on Form H1020, Request for Information or Action.
    - Manually generate the Form H1020 and attach the Form HRG-83, SSN Maintenance Memorandum, before mailing.

If the person:

- Returns all requested information and staff verify the SSN, certify the person if all other eligibility requirements are met.
- Returns all requested information, but staff are unable to verify the SSN with the information provided, certify the person if all other eligibility requirements are met.
- Returns information, but not the information to clear the SSN discrepancy, certify the person if all other eligibility requirements are met.
- Does not return requested information, disqualify or deny the person.

If the person's identity is questionable, request information to clear the discrepancy. If the information is not provided or the information provided does not clear the discrepancy, disqualify, or deny the person.

If unable to verify a person's SSN via SOLQ, the monthly SSA interface will attempt to validate the SSN. If the monthly interface does not validate the SSN, TIERS generates Alert 268, *Social Security Administration Unable to Verify SSN (RG-83)*, or Alert 269, *Social Security Administration Reports a Duplicate SSN*, to address the discrepancy.

Related Policy

Social Security Numbers (SSNs), A-144.1

Postponed Verification Procedures, A-145.1

Failure to Comply, A-420

SSN Discrepancy Clearance Procedures, A-432

Verification Requirements, A-440

Questionable Information, C-920

A-420, Failure to Comply

Body

Revision 24-2; Effective April 1, 2024

TANF and SNAP

If an application is certified but a household member is disqualified, notification of the person's disqualification is included on the comment section of Form TF0001, Notice of Case Action.

Related Policy

TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction, A-1362.2
SNAP — Budgeting for Members Disqualified for Citizenship, SNAP ABAWD Work Requirement or Noncompliance with Social Security Number Requirements, A-1362.3

TANF

Disqualify a required member of the certified group who fails to comply without good cause.

Exception: Deny TANF if the:

- only eligible child or otherwise eligible person does not comply; or
- caretaker or payee refuses to cooperate and eligibility cannot be determined for the other members.

SNAP

Disqualify an applicant who fails to comply unless a social security number (SSN) cannot be provided because:

Exception: Follow policy in A-410 for the following situations:

- the person is a child under six months;
- the household is eligible for expedited service; or
- good cause exists for the applicant.

Related Policy

General Policy, A-410

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

Deny a person's eligibility if they fail to comply with the SSN requirements unless they meet a good cause reason. Denying a person's eligibility who does not comply with SSN requirements does not impact the eligibility for any other people applying for or receiving Medical Program benefits.

Related Policy

General Policy, A-410

A—421 Reestablishing Eligibility

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If a member is disqualified at application and later complies, the individual is included effective the month after being notified of the compliance.

A-430, Proof Required by SSA

Body

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

The proof required to get an SSN is shown in the table below, except for special situations that are listed in A-431, Special Situations. The proof needed depends on:

- place of birth;
- citizenship status; and
- whether the request is for an original, duplicate, or corrected SSN.

If the applicant is a or an ...	applying for ...	then the applicant must furnish proof of ...
U.S. citizen born in the U.S.,	an original SSN,	age, identity, and citizenship.
U.S. citizen born in the U.S.,	a duplicate SSN,	identity.

If the applicant is a or an ...	applying for ...	then the applicant must furnish proof of ...
U.S. citizen born outside the U.S.,	an original SSN,	age, identity, and citizenship.
U.S. citizen born outside the U.S.,	a duplicate SSN,	identity and citizenship.
alien,	an original SSN,	age, identity, and lawful alien status.
alien,	a duplicate SSN,	identity and lawful alien status.

Note: To correct/update SSN information, the applicant must provide proof required for a duplicate SSN as well as proof showing the new information.

Acceptable Proof

The documents must be originals, or copies made by the custodian of the record, such as a county clerk or registrar. SSA will return all documents submitted to SSA.

Proof of Age and Citizenship

A birth certificate is the preferred proof.

If no birth certificate is available, **a U.S.-born citizen** may furnish:

- a religious record showing age or date of birth (to establish citizenship, it must have been recorded within three months of birth);
- a hospital birth record;
- a notice of birth registration; or
- other documents, at least one year old, that show:
  - name,
  - age or date of birth, and
  - place of birth.

If no birth certificate is available, **a foreign-born U.S. citizen** may furnish a:

- U.S. Consular Report of Birth,
- U.S. Citizen Identification Card (Form I-197),
- Certificate of U.S. Citizenship (Form N-560),
- U.S. Passport, or
- Certificate of Naturalization (Form N-550 or N-570).

Proof of lawful alien status:

- I-551, Permanent Resident Card (Resident Alien Card);
- I-151, Alien Registration Receipt Card;
- I-94, Arrival-Departure Record; or
- I-688A, Employment Authorization Card.

Proof of Identity

Proof of identity must contain enough information to identify the applicant, such as name, age or date of birth, address, signature, and physical description. Examples of acceptable documents are:

Acceptable Documents
Adoption record
Work identification card
Medical record or vaccination record
Driver's license
Insurance policy
U.S. passport
School record or report card
Marriage or divorce record
Voter registration

A-431 Special Situations

Revision 19-4; Effective October 1, 2019

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

The following situations require special handling.

- If the SSN applicant is a non-U.S. citizen who traditionally uses a name order different from the customary U.S. name order (first name, middle name, last or family name), determine name order according to U.S. custom and enter appropriately on Form H1106, Enumeration Referral.

Examples:

Example	Last	First	Middle
Vietnamese name on I-94:	Nguyen	Thi	Mai

Example	First	Middle	Last
Enter name on Form H1106:	Thi	Mai	Nguyen

A-432 SSN Discrepancy Clearance Procedures

Revision 24-4; Effective Oct.1, 2024

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

The monthly Social Security Administration (SSA) interface tries to verify the SSN after certification when a person's Social Security Number (SSN) is not verified through the State Online Query (SOLQ) automated system. If the SSN cannot be verified during the interface or a duplicate SSN is found, one of the following alerts is generated:

- Alert 268, Social Security Administration Unable to Verify SSN (RG-83) when the information does not match. This triggers the Task List Manager (TLM) Alert 268, Agency Generated Change - Social Security Administration Unable to Verify SSN (RG-83) for Client (Individual ID) XXXXXXXXX, and routes it to the Customer Care Center (CCC) for case action; or
- Alert 269, Duplicate SSN for Individual Number, when the SSN is a duplicate. This triggers the TLM Alert 269, Agency Generated Change - Social Security Administration Reports a Duplicate SSN XXXXXXXXXX, and routes it to the CCC for case action.

Upon receipt of Alert 268 or Alert 269, research the case and contact the household to clear the discrepant or duplicate SSN. If unable to clear the discrepant or duplicate SSN and the person does not have good cause for not providing a SSN, the following correspondence is generated and the person has a 60-day period to clear the discrepancy:

- Form TF0001, Notice of Case Action, with the following language in the Notes section of the form:

  The person is granted extra time to resolve the problem with their Social Security Number.

  We need proof that you have gone to the Social Security Administration to resolve the issue with XXXXXXX XXXXX's Social Security Number by XX/XX/XXXX. If we don't receive the proof, your XXXXXX benefits will end.
- Form HRG-83, SSN Maintenance Memorandum, instructing the household to go the SSA office to correct or update the person's Social Security records.

SSA staff will help the person complete an application to correct or update their Social Security records and will provide them with Form SSA-5028, Receipt for Application for a Social Security Number as proof.

If the person's SSN has not been validated by the 60th day from the date the Form TF0001 and Form HRG-83 are sent, staff are prompted to review the case via Alert #796, Reasonable Opportunity Period has Expired for EDG #.

If the person fails to cooperate in clearing the discrepancy with the SSA or if the SSN has not been validated, refer to related policy to disqualify or deny the person.

Note: This 60-day period is different from the Medicaid reasonable opportunity period for applicants to provide verification of U.S. citizenship or an eligible alien status, when verification is not available when the person applies.

If the system shows an SSN was verified, but the SSN needs to be corrected, send the correct SSN to Data Integrity (DI) to make a change by one of the following methods:

Mail to: DI Section, Data Base Support
4616 W Howard Ln,
Suite 275, MC Y92-2
Austin, TX 78728

Fax to Data Base Support at 512-483-3992.

Email the request to the Data Integrity email box at HHSC CCC Data Integrity Program.

Include in the body of the email:

Case number:

Client name:

Individual number:

Situation:

DI staff send an email to the staff member stating the request was processed or it was unable to process request with substantiation.

Related Policy

Failure to Comply, A-420

A-440, Verification Requirements

Body

Revision 20-2; Effective April 1, 2020

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

Verify that a household member applied for a SSN when the applicant cannot provide an SSN. Refer to A-410, General Policy, for applicable exceptions, by program.

SSNs are verified through:

- State Online Query (SOLQ) being invoked during Data Collection. Verification of an SSN via this process is identified in both the Individual Household Summary page with a checkmark in the box by the person's SSN **and** a checkmark in the Validated by SSA checkbox on either the Data Collection/Add New Individual page, the Modify Non File Cleared Individual page, or the Edit Existing Individual page.
- The monthly SSA interface. Verification of an SSN via this process is identified in the Individual Summary Page when the SSA box is checked for the individual.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

Follow policy in A-351.2, Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship, for verifying SSN using SOLQ or Wire Third-Party Query (WTPY).

If unable to verify the SSN using SOLQ or WTPY:

- Review the information entered into the SOLQ or WTPY request with the information provided by the applicant. If a typographical error is found, submit a new SOLQ or WTPY request with the correct information.
- If no typographical errors are found, contact the applicant by phone to ensure the information provided is accurate. If the applicant provides new information, submit another SOLQ or WTPY request with the correct information. Update the EDG record with the correct information.
- If unable to contact the applicant by phone, send the applicant Form H1020, Request for Information or Action, to request verification of the applicant's SSN along with any additional information needed. Allow the person 10 days to provide proof.
- If the person fails to cooperate in clearing the discrepancy with the SSA, follow policy in A-420, Failure to Comply.

Follow policy in A-410 to verify all good cause reasons to providing an SSN.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A—441 Verification Sources

Revision 15-4; Effective October 1, 2015

All Programs

For SSN discrepancies or SSNs that cannot be verified through the SSA interface, SOLQ, or WTPY, the applicant must provide one of the following:

- Copy of the SSN card; or
- Social Security Administration letter confirming the SSN.

Acceptable proof of application of an SSN includes:

- Form SSA-5028, Receipt for Application for an SSN, less than 30 days old;
- Form SSA-2853, Message From Social Security, less than 180 days old; and
- Form H1106, Enumeration Referral.

Medical Programs

Form H1106, completed by the Social Security Administration, is the acceptable verification source for not providing an SSN due to ineligibility to receive an SSN or eligibility to receive an SSN only for a valid non-work reason. Advisors must review the response provided by the SSA on the Form H1106 to determine which good cause reason the applicant meets.

Acceptable sources of verification for a well-established religious objection include:

- an approved IRS Form 4029, Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits; or
- a letter from a leader of the religious organization, a document setting out the tenets of the religious organization which justify the good cause reason, or a similar document.

Note: If the source of verification for a religious exemption is questionable, advisors must contact their supervisor who will coordinate with the Texas Health and Human Services Commission (HHSC) regional attorneys to ensure the documentation is sufficient.

A-450, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

In the Data Collection/Individual Demographics-SSN/Armed Services page, the advisor must enter the date the individual was given Form SSA-5028, Receipt for Application for an SSN, or Form SSA-2853, Message From Social Security, or the date the applicant returned Form H1106, Enumeration Referral. For EDGs with an individual currently being enumerated, the advisor sends the following documents for imaging:

- Form H1106,
- a copy of Form SSA-5028, or
- a copy of Form SSA-2853.

Advisors must document that the SSA enumerated the individual or was unable to do so.

Related Policy

Documentation, C-940

SNAP

Advisors must document good cause claims according to A-410, General Policy.

Related Policy
The Texas Works Documentation Guide

A-500, Age/Relationship

A-510, Age Limits

Body

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

For age requirements, see household composition:

- A-220 for TANF, and
- A-240 for Medical Programs.

A-520, Relationship

Body

Revision 13-2; Effective April 1, 2013

A-521 Eligibility Requirements

Revision 21-1; Effective January 1, 2021

TANF

A child must live, or be expected to live, in the home of one of the relatives (either biological or adoptive) listed in A-221, Who Is Included, No. 4, Caretaker.

TANF-SP

A child must live with, or be expected to live, with both legal parents, or one legal parent and a stepparent.

Note: This also includes legal parents or stepparents who are disqualified for one of the reasons listed in A-222, Who Is Not Included, No. 4, Disqualified Members, unless that disqualification is due to not meeting citizenship requirements.

TP 08 and TA 31

To qualify for TP 08 or TA 31, a person must be a:

- legal parent of a dependent child (both legal parents can be eligible);
- caretaker relative of a dependent child; or
- spouse of a caretaker relative.

The caretaker must be a:

- parent;
- stepparent*;
- sibling;
- step-sibling;
- grandparent;
- uncle or aunt;
- nephew or niece;
- first cousin; or
- first cousin once removed.

*A stepparent of a dependent child is considered within the degree of relationship for TP 08, Parents and Caretaker Relatives Medicaid, and TA 31, Parent and Caretaker Relative Medicaid - Emergency. The relationship to the dependent child remains even if the legal parent and stepparent are divorced or the legal parent is deceased.

The spouse of a caretaker relative may also be eligible for medical coverage if they live with the caretaker relative who cares for the dependent child receiving Medicaid.

Example: A grandfather is the caretaker relative of his granddaughter. The grandfather applies for Medicaid for himself, his granddaughter, and his spouse who lives with him. If the granddaughter is eligible for Medicaid, both the grandfather and his spouse may be eligible for TP 08.

A dependent child is a person who:

- is under age 18; or
- if age 18, attends school full-time and expects to graduate in or before the month of their 19th birthday. **Note**: A child who will not graduate until after the month of their 19th birthday is not considered a dependent child after the month of their 18th birthday.

TP 32, TP 33, TP 34, TP 35, TP 43, TP 44, TP 48 and TP 56

To be eligible for these programs, a child can:

- live with the child's parents;
- live with a caretaker within the degree of relationship required for TP 08 and TA 31;
- live with a person not within the degree of relationship required for TP 08 and TA 31;
- be abandoned; or
- live independently.

TP 45

A child whose mother is eligible for and is receiving Medicaid coverage when the child is born, or whose mother is eligible for and receives Medicaid coverage retroactively for the time of the child's birth, is eligible for TP 45 coverage. The Medicaid coverage for the newborn can continue through the month of the child's first birthday if the child remains in Texas, even if the child does not reside with the birth mother.

Related Policy
Guide for Determining Relationship, C-1441
Guide for Determining Extended Relationships, C-1442

A-522 Legal Parent-Child Relationship

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

A legal parent-child relationship exists between a child and:

- an adoptive parent by proof of adoption;
- the mother by proof of having given birth to the child; or
- a man if one of the following conditions exist:
    - The man and the mother married (including a common-law marriage) in apparent compliance with the law before the child's birth (even if the marriage is or could be voided), and the child was born:
        - while they were married; or
        - within 300 days after the marriage terminated.
    - The man and the mother married (including a common-law marriage) in apparent compliance with the law after the child's birth (even if the marriage is or could be voided), and the man:
        - filed a paternity suit, including a statement of paternity in court;
        - is named the father on the child's birth certificate; or
        - has a written obligation to support the child voluntarily or by court order.
    - The courts determine that the man is the biological father.

If there is no other legal father, a legal parent-child relationship exists between a man and a child if one of the following conditions exists:

- The man and the mother do not marry, but the man consents in writing to be named as the child's father on the child's birth certificate.
- Before the child turns age 18, the child lived with the man and holds out to the public that the man is the child's father.
- The man signs an acknowledgement of paternity (AOP) with the Office of Attorney General or Vital Statistics Unit. The child's mother must also be available to sign the AOP.

A-523 When Proof of Relationship Is Unavailable

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

If Birth Verification System (BVS) records do not establish relationship or the applicant cannot provide proof of relationship shown in A-531, Verification Sources, the advisor must use alternative ways to determine relationship. See A-523.1, How to Make an Evaluative Conclusion.

A-523.1 How to Make an Evaluative Conclusion

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

The advisor must examine all available proof such as (but not limited to) school records, court records, birth records, health records, insurance policies, refugee's voluntary resettlement agency (VOLAG) or the U.S. Citizenship and Immigration Services (USCIS) records, or other sources of proof that provide the same information. The advisor should offer reasonable assistance if the individual has difficulty obtaining the information.

Advisors must obtain supervisory approval of the evaluative conclusion.

A-523.2 Children Living with Biological Father

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

A biological father may receive TANF, TP 08, or TA 31 if the biological father proves relationship. If the father cannot provide acceptable proof, the advisor must make an evaluative conclusion to establish relationship for the father and child. The OAG uses the automated child support referral to locate the mother and establish paternity of the biological father. The OAG notifies the advisor via Form H1701, Child Support, TANF Foster Care and TANF/Medicaid Case Information Exchange, that paternity is established or excluded. If paternity is excluded, advisors must process an overpayment claim for the period of time the household erroneously received benefits as specified in B-700, Claims.

Proof of a court determination of paternity is required if, at the time of the child's birth, the child's mother was married to another man who is presumed to be the child's legal father.

A-523.2.1 Children Living with Relatives of Biological Father

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

To qualify for TANF or Medical Programs, a caretaker relative must establish required relationship to the child as specified in A-221, Who Is Included, following the steps below:

The caretaker relative must provide acceptable proof of relationship between:

- the caretaker and the biological father; and
- the biological father and the child, using the conditions listed in A-522, Legal Parent-Child Relationship.

A—530 Verification Requirements

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

Advisors must verify the age and relationship of each child to the adult claiming the relationship before certifying or adding the child to the cash grant and/or before certifying the adult for Medicaid. Advisors use BVS inquiry for someone born in Texas and who is at least 46 days old but less than 19 years old.

See A-531, Verification Sources. If these verifications are not available, make an evaluative conclusion. See A-523.1, How to Make an Evaluative Conclusion.

Related Policy

Birth Verification System, C-860

A-530, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

Advisors must verify the age and relationship of each child to the adult claiming the relationship before certifying or adding the child to the cash grant and/or before certifying the adult for Medicaid. Advisors use BVS inquiry for someone born in Texas and who is at least 46 days

old but less than 19 years old.

See A-531, Verification Sources. If these verifications are not available, make an evaluative conclusion. See A-523.1, How to Make an Evaluative Conclusion.

Related Policy

Birth Verification System, C-860

A—531 Verification Sources

Revision 24-3; Effective July 1, 2024

TANF and Medical Programs

Verify the age and relationship requirements using the following verification sources.

Age

- birth certificate;
- hospital or public health birth records;
- church or baptismal birth record;
- BVS inquiry;
- local, state, federal or military record;
- adoption papers or records;
- Indian census records;
- U.S. passport;
- school or day care records;
- U.S. Citizenship and Immigration Services records;
- Attorney General child support paternity records; or
- Social Security Administration records.

Alternate Age Sources

- court or child welfare records;
- insurance policies;
- family Bible records;
- voluntary social service agency records;
- court child support order;
- written statement from a doctor or clergy member who knows the date of birth;
- juvenile court records;
- census records; or
- written statement from a non-relative who knows the date of birth.

Relationship

- birth certificate;
- adoption papers or records;
- hospital or public health records of birth and parentage;
- BVS inquiry;
- church or baptismal birth record;
- local, state, federal government or military record;
- school or day care records;
- U.S. Citizenship and Immigration Services records;
- Attorney General child support paternity records;
- juvenile court records;
- Indian census records;
- U.S. passport;
- marriage license or certificate;
- divorce papers; or
- court records of parentage.

Alternate Relationship Sources

- church records of parentage and relationship including statement from clergy;
- family Bible records;

- court or child welfare records;
- insurance policies;
- voluntary social service agency records;
- statement from clergy, doctor or school official who can verify relationship;
- statement from non-relative who has known the child since birth;
- Declaration of Informal Marriage filed with the county clerk;
- sworn statement signed by both spouses; or
- Form H1057, Declaration of Informal Marriage.

Medical Programs except TP 08 and TA 31

If other sources are unavailable, verify the age and relationship requirements using the household's written or verbal statement.

Related Policy

Documentation Requirements, A-540
Questionable Information, C-920
Providing Verification, C-930

A-540, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Advisors must document proof of age or relationship and the basis for the evaluative conclusion or enter on the Texas Integrated Eligibility Redesign System (TIERS) Individual Household page and the Relationship page.

Advisors must document the following:

- The verification source.
- The verification date.
- Children's names.
- Information from the verification source to prove the children live in the home (for collateral contacts include name and address and/or phone number).
- Reason for any temporary absence.
- Information from the verification source to prove the household member or payee returned to and lived in the home for at least 30 days when allowing another temporary absence period.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

A-600, Identity

A-610, General Policy

Body

Revision 07-4; Effective October 1, 2007

A-611 At Application

Revision 26-2; Effective April 1, 2026

TANF

Verify the identity of the **person interviewed**. Once identity is verified for a person, do not re-verify.

Related Policy

Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Verify the identity of **all applicants requesting benefits.** Once identity is verified for a person, do not re-verify.

Verify the identity of the person interviewed if questionable, if an interview was requested or conducted.

Related Policy

Verification of Citizenship, A-351

SNAP

Verify the identity of the **person interviewed.**

Verify the identity of both the AR and the person the AR represents If the authorized representative (AR) applies for the household.

Exception: If necessary to meet expedited service time limits, staff only need to verify the identity of the AR being interviewed.

Related Policy

Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

A-612 Redetermination

Revision 26-2; Effective April 1, 2026

SNAP and TANF

Verify the identity of the **person interviewed** if not previously verified.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Verify the identity of **each person requesting benefits** during the redetermination, if identity was not previously verified. Once identity is verified for a person, do not re-verify.

Related Policy

Verification of Citizenship, A-351
Citizenship, A-358.1
Verification Sources, A-621
Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

A-613 Receipt of Lone Star Card and/or PIN

Revision 15-4; Effective October 1, 2015

SNAP and TANF

Advisors must verify the identity of a person receiving a Lone Star Card and/or personal identification number (PIN) (initial issuance or replacement).

A-620, Verification Requirements

Body

Revision 03-5; Effective July 1, 2003

All Programs

Birth records and other official records are preferred sources of verification.

A-621 Verification Sources

Revision 25-3; Effective July 1, 2025

SNAP and TANF

Verify identity using the following verification sources:

- Adoption papers or records
- Birth certificate - refer to **Note**: under this bulleted list
- Certificate of Naturalization
- Certificate of U.S. citizenship
- Collateral statement
- Driver license or Department of Public Safety (DPS) identification (ID) card, current or expired
- Finding of citizenship by another federal or state agency
- Hospital or birth records
- Immigration documents
- Self-declaration of driver license or:
  - DPS ID number already on file, along with other identifying information such as date of birth; or
  - DPS ID number listed on Data Broker, along with other identifying information such as date of birth.
- U.S. passport or U.S. passport card
- Voter registration card
- Wage or check stubs or check
- Work or school ID card

Note: People born in Puerto Rico must provide a birth certificate issued on or after July 1, 2010, unless certified previously using a birth certificate issued before July 1, 2010. Staff are responsible for helping a person get birth verification from Puerto Rico.

TP 08, TP 43, TP 44, TP 48, TP 40 and TA 31

Copies of the document used to verify identity **for people requesting benefits** must be legible and non-questionable. Submit the document for imaging.

Identity and Citizenship

Verify both identity and citizenship for Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36.

Identity Only

Use one of the following sources as acceptable verification if the document has a photograph and other identifying information such as name, age, date of birth, sex, race, height, weight, eye color or address:

- Driver’s license issued by a state or territory;
- School identification card;
- U.S. military card or draft record;
- Identification card issued by the federal, state, or local government with the same information included on driver’s licenses;
- Military dependent's identification card;
- U.S. Coast Guard Merchant Mariner card; or
- Native American Tribal document.

Use two or more corroborating documents, including but not limited to:

- marriage licenses, divorce decrees or high school diplomas;
- for children under 19, a clinic, doctor, hospital or school record, including preschool or day care records; and
- Form H1097, Affidavit for Citizenship/Identity, signed by another person who can reasonably declare to the applicant’s citizenship, regardless of blood relationship to the person and under penalty of perjury, and that contains the applicant’s name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized, and the Form H1097 should be used only as a last resort when other evidence is not available.

Note: A signed application for Medicaid, including the signature of an authorized representative acting on the person’s behalf, is applicable for all household members on the application except the signee. No person may declare their own identity.

Related Policy

Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship, A-351.2
Citizenship, A-358.1
Questionable Information, C-920
Providing Verification, C-930
Advisor Responsibility for Verifying Information, C-932

A-630, Documentation Requirements

Body

Revision 26-1; Effective Jan. 1, 2026

All Programs

Document how the identity of the person interviewed was verified.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Document how the identity of **each person requesting benefits** was verified. Copies of the document used to verify identity must be legible, non-questionable. Submit the document for imaging.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide (PDF)

A-700, Residence

A-710, General Policy

Body

Revision 18-1; Effective January 1, 2018

All Programs

Applicants must live in Texas to be eligible for benefits. The household is not required to have a permanent dwelling or fixed residence.

TANF and Medical Programs

Individuals who live in Texas (other than for migrant or itinerant work) meet the residency requirement if they are living in Texas intending to remain in Texas. People who live in Texas for a temporary purpose do not meet the residency requirement.

The person's residence becomes questionable when the post office returns Texas Health and Human Services Commission (HHSC) correspondence or benefits as undeliverable.

Migrant and itinerant workers meet the residency requirement when applying if they:

- live in the state;
- entered the state with a job commitment or an intention to seek employment (regardless of current employment status); and
- do not receive assistance from another state.

SNAP

People who live in Texas for any purpose other than a vacation meet the residency requirement, regardless of the length of time they have been here or plan to stay.

Related Policy

Form TF0001 Required (Adequate Notice), A-2344.1

A-720, New Texas Residents

Body

Revision 24-2; Effective April 1, 2024

All Programs

A person cannot participate in more than one state in any month.

Use these resources to contact agencies in other states to verify if a new Texas resident's benefits have ended in another state:

- Medicaid and CHIP program contact information;
- The National Directory of SNAP Agencies on The LOOP; or
- TANF program contact information.

Medical Programs

New Texas residents may receive overlapping Medicaid coverage.

SNAP

Residents in an approved shelter for battered persons may participate twice in the month of application if they participated first with the person who abused or threatened them with abuse.

Related Policy

Medicaid Coverage for New State Residents, A-822

A-730, Moves Within Texas

Body

Revision 15-4; Effective October 1, 2015

All Programs

Individuals keep their residence status when they move within Texas.

TANF and SNAP

A person cannot participate as a member of more than one household in any month.

SNAP

Residents in an approved shelter for battered persons may participate twice during the month of application if they participated first with the person who abused them or threatened them with abuse.

Related Policy

Household Composition, A-200

A-740, Moves Out of Texas

Body

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

A certified individual becomes ineligible if the individual moves to another state:

- with the intent to remain there, or
- without declaring intent to return.

If the individual returns to Texas within 90 days and states that the move was not intended to be permanent, the advisor must:

- reopen the Eligibility Determination Group (EDG) using the reason denied-in-error; and
- issue restored benefits, if appropriate.

SNAP

A household is not eligible for benefits issued for a month after the household leaves Texas.

When a household member notifies HHSC that the household moved out of Texas, Form TF0001, Notice of Case Action, is not required. If the household has not yet moved, the advisor must issue Form TF0001 to provide adequate notice. The EDG is denied effective the end of the month they move, if possible.

Related Policy

Canceling Benefits, B-330

A-750, Temporary Visits Out of Texas

Body

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Individuals do not lose their residence status when they temporarily leave Texas.

An individual can be absent from Texas for any length of time. Advisors must review the situation every three months to determine the individual's intent to maintain Texas residence. The individual must reasonably explain:

- the purpose for leaving Texas,
- the intent to return to Texas, and
- which state the individual claims residency in.

An individual is a resident of Texas unless there is substantial, factual evidence that proves otherwise. When the advisor determines that the individual is no longer a resident, the individual is denied.

SNAP

A person is not eligible for SNAP in Texas for any month the individual is out of Texas the entire month.

A-760, Verification Requirements

Body

Revision 24-4; Effective Oct.1, 2024

All Programs except TP 33, TP 34, TP 35, TP 43, TP 44, TP 45, TP 48 and TP 56

Verify the actual physical address of a household at each application and redetermination.

Verify the last month any benefits were issued when an applicant recently moved to Texas from another state.

When staff cannot verify residence with readily available evidence, they must:

- contact the landlord, neighbors, or other sources of reliable information; or
- observe personal effects and living arrangements.

Note: If any household residence is questionable, staff may require the household provide a more reliable source of verification, such as one of the primary verification sources. Do not restrict the additional verification requested to a specific source from that list.

TANF and Medical Programs

Determine if the household plans to remain in Texas at each application and redetermination.

TP 40

Postpone verifying residence if trying to meet expedited service time frames.

TP 33, TP 34, TP 35, TP 43, TP 44, TP 45, TP 48 and TP 56

Verify residency using the household's statement, unless questionable.

Related Policy

Prudent Person Principle, A-137
Expedited Service, A-140
Special Treatment for Households Meeting Categorical Eligibility Criteria, B-472
Questionable Information, C-920

A-761 Verification Sources

Revision 22-2; Effective April 1, 2022

All Programs except Children's Medicaid

The following are acceptable sources to verify the household's current address:

- utility bills or utility company records;
- rent receipt or statement from non-relative landlord;
- mortgage receipt or statement from mortgage company;
- valid Texas driver license or Department of Public Safety (DPS) identification card;
- Data Broker residence reported on the DPS data field;
- Department of Motor Vehicles record;
- school records;
- voter registration card;
- statement from child care provider;
- employment records or statement from employer;
- official records confirming ownership of property;
- home visit;
- SOLQ for Social Security benefit recipients, including those receiving Medicare;
- item of mail with household name and address;
- other HHSC correspondence the applicant can provide showing the household received it at the applicant's current Texas address;
- inquiry into Office of the Attorney General (OAG), Texas Workforce Commission (TWC) or another entity's automated system, outside of HHSC, showing the same Texas address currently reported by the household;
- a local landline number the applicant provides (not a cell phone number) that is either listed in the phone book or an online directory with the same Texas address the household currently reports, or the household can be contacted at that local phone number when conducting a phone interview;
- searches resulting in a match between the address and the phone number provided by the applicant using the Data Broker Search Options Menu, Telephone Number Search;
- post office records;
- city or crisscross directory;
- church records; or
- statement from non-relative.

Exception: Self-declaration of residence is acceptable when certifying a child for TP 56, MA - Medically Needy with Spend Down.

TANF and Medical Programs

The applicant's statement of intent to remain in Texas is acceptable.

Children's Medicaid

Self-declaration.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A-770, Documentation Requirements

Body

Revision 24-4; Effective Oct. 1, 2024

All Programs

Document:

- the household's proof of address; and
- all efforts to verify residence if unusual circumstances make residency verification difficult.

TANF and Medical Programs

For temporary visits outside of Texas, document the household member's:

- purpose for leaving the state;
- intent to return to Texas; and
- state they consider their residence.

Related Policy

Prudent Person Principle, A-137
Documentation, C-940
The Texas Works Documentation Guide

A-800, Medicaid Eligibility

A-810, General Policy

Body

Revision 16-4; Effective October 1, 2016

Medical Programs

Applicants may receive Medicaid during the three-month period before the month they apply for Medicaid. See A-831, Three Months Prior Coverage, for eligibility criteria and application procedures.

Some former individuals on TP 08, TP 43, TP 44, and TP 48 remain eligible for Transitional Medicaid after their eligibility is denied. See the chart that follows for more information.

Reason for Denial	Type Program	Who Is Covered?
Alimony/Spousal support	TP 20 (A-850, Alimony/Spousal Support Transitional Medicaid Coverage)	The household
New or increased earnings	TP 07 (A-842, TP 07 Transitional Medicaid)	The household

Most adopted children receive Medicaid through the Texas Department of Family and Protective Services (DFPS). DFPS works with the Interstate Compact on Adoption and Medical Assistance (ICAMA) to facilitate the timely delivery of Medicaid coverage when a family moves or the adoption involves an interstate placement. If an adopted child is receiving Medicaid in another state, the parent must contact the originating state to coordinate and transfer Medicaid coverage information to Texas. If an adoptive parent has any questions about the adoptive child's Medicaid, advisors should inform them to contact their local DFPS office for assistance.

Medical Programs, Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB)

Individuals receiving some Texas Works Medicaid types of assistance may also qualify for the Medicaid for the Elderly and People with Disabilities (MEPD) Medicare Savings Program types of assistance, MC – QMB (TP 24) or MC – SLMB (TP 23), if they meet the eligibility criteria. See policy in the *Medicaid for the Elderly and People with Disabilities Handbook*, Q-2000, Qualified Medicare Beneficiaries (QMB) — MC-QMB.

Individuals may receive QMB and the following types of assistance:

- MA – Earnings Transitional (TP 07)
- MA – Parents and Caretaker Relatives (TP 08)
- MA – Pregnant Women (TP 40)

- MA – Children Under 1 (TP 43)
- MA – Newborn Children (TP 45)
- MA – Children 1-5 (TP 48)
- MA – Children 6-18 (TP 44)
- MA – Former Foster Care Children (FFCC) (TA 82)

The above programs cannot be dually eligible for SLMB. Even though these programs may meet SLMB eligibility requirements, the Medicare Part B premium is already paid. An individual can be dually eligible for MA – MN with Spend Down (TP 56) and SLMB.

A-820, Regular Medicaid Coverage

Body

Revision 26-1; Effective Jan. 1, 2026

Medical Programs

Regular Medicaid eligibility begins the day an applicant meets all eligibility criteria. The medical effective date (MED) cannot precede:

- a newborn's date of birth (DOB);
- the date a child enters the home;
- the start date of the emergency condition for a person eligible for Emergency Medicaid;
- the date a disqualified parent or caretaker relative complies; and
- the month at least one eligible dependent child is certified for Medicaid.

Note: Assign the DOB as the MED for a child born to a woman incarcerated in the Texas Department of Corrections at Gatesville when contacted by HHSC staff housed at the University of Texas Medical Branch (UTMB) Hospital. Document this contact in Case Comments.

For parent or caretaker relative's Medicaid, the MED cannot precede:

- the newborn's date of birth when the newborn is the only eligible child; or
- the date a child enters the home when the newborn or entering child is the only eligible child.

The eligibility determination system assigns an earlier MED if the parent or caretaker relative has unpaid medical bills and would have been eligible for Medicaid as a pregnant woman from the first day of her newborn's birth month.

If the only child of a parent or caretaker relative eligible for TP 08 dies before certification, process an application for Medicaid for a deceased person. Certify coverage for the child through the date of death and for the parent or caretaker relative through the remainder of that month.

TP 40

Medicaid for a pregnant woman the first day of the month her pregnancy starts, not before. The verbal or written statement from the applicant, pregnant woman, head of household or authorized representative (AR) is an acceptable source of verification for the start month, the number of expected children, and the anticipated delivery date.

If the applicant's verbal or written statement is not available, use one of the acceptable verification sources to get the pregnancy start date and anticipated delivery date.

If information is requested but not returned by the 15th business day from the file date, deny the application. Reopen the application if the person provides verification by the 60th day from the file date.

Exception: Do not request verification of pregnancy if the:

- application is processed after the pregnancy terminates; and
- applicant provides proof of the newborn child's birth.

A pregnant woman remains continuously eligible through the 12th month following the month her pregnancy ends if all other eligibility requirements are met and countable income is below the income limits in:

- the application month; or
- one of the three months before the application month if in the prior month she:
  - had unpaid Medicaid-reimbursable bills; or
  - received services from the Texas Department of State Health Services (DSHS).

Example: A pregnant woman applies for Medicaid in June 2024. Her expected delivery date is December 2024. She has unpaid medical bills in March 2024 and meets all other eligibility requirements. She does not have any unpaid medical bills in April or May 2024. Certify her for Medicaid from March 2024 through December 2025.

After determining a pregnant woman is eligible for TP 40, the woman remains continuously eligible regardless of any changes unless she:

- voluntarily withdraws;
- moves out of state;
- is ineligible due to agency error or fraud, abuse or perjury attributed to the person; or
- dies.

Note: If a woman certified for Healthy Texas Women (HTW) reports her pregnancy, the HTW and Medicaid for Pregnant Women (TP 40) coverage may overlap because HTW does not provide prenatal or pregnancy benefits. In this situation, HTW is denied prospectively, and the woman is enrolled in TP 40 beginning the first day of the month she meets all eligibility criteria.

If a woman who was certified for expedited benefits provides postponed verification that prove she does not meet eligibility requirements, provide advance notice of adverse action and deny her coverage.

TP 45

Before providing initial TP 45 coverage for a newborn child, verify that the:

- mother was:
  - eligible for and received Medicaid in Texas on the day the child was born;
  - retroactively eligible for Medicaid for the day the child was born;
  - continuously eligible for Medicaid or would have been eligible if pregnant, during the child's birth month; and
- child lives in Texas.

Note: A newborn child born to a mother who received Emergency Medicaid coverage at the child's birth is eligible to receive TP 45 coverage from the date of birth through the end of the month of the child's first birthday.

The MED for the initial certification is always the child's date of birth.

Before resuming coverage for a newborn who was denied TP 45, verify that the child lives in Texas.

TP 56

Medicaid coverage for children or pregnant women with spend down begins the first day the household meets the spend down amount.

- Pregnant women who meet the spend down amount receive TP 56 coverage through their pregnancy; and
- 12-month postpartum period without being required to meet the spend down amount again.

Note: A woman certified for HTW may have overlapping coverage with TP 56 if she has unpaid medical bills related to her pregnancy because HTW does not provide full coverage benefits.

The applicant meets spend down by submitting or having a provider submit eligible medical bills to the Clearinghouse.

The Clearinghouse:

- determines when the person meets spend down; and
- notifies HHSC by an interface. The eligibility determination system sets the MED for the certified members.

Note: The Clearinghouse may discover a discrepancy while processing a spend down EDG. Processing is put on hold and the EDG is referred to Data Integrity (DI) to research. DI sends a memo to staff asking for information to clear the discrepancy. Respond timely to these requests so that the Clearinghouse can complete the spend down process.

Emergency Medicaid (TA 31, TP 32, TP 33, TP 34, TP 35, TP 36)

Medicaid eligibility begins on the start date of the emergency medical condition verified by the attending practitioner on Form H3038, Emergency Medical Services Certification, or Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification.

A pregnant woman certified for Emergency Medicaid will receive Emergency Medicaid coverage through the 12-month postpartum period.

A child under 19 certified for Emergency Medicaid receives Emergency Medicaid coverage for a continuous 12-month certification period.

Only services needed to stabilize the patient's condition during an emergency or life-threatening situation are covered. Services provided after the emergency condition becomes stable are not covered.

TP 36

TP 36 recipients do not have to submit another Form H3038 or Form H3038-P during the 12-month postpartum period for any subsequent emergency events. Do not process the TP 36 certification as an open and close segment. The eligibility determination system automatically provides the 12-month certification and postpartum period.

If the TP 36 recipient submits a change or new application reporting a new pregnancy during the 12-month postpartum period, certify the recipient for CHIP-P, if eligible, and maintain the current TP 36 12-month postpartum period. The eligibility determination system also creates a new EDG for the new postpartum period.

Note: Households with income at or below 198% of the Federal Poverty Limit (FPL) can receive concurrent CHIP-P and TP 36 coverage. CHIP-P coverage ends on the last day of the pregnancy termination month, while TP 36 coverage continues through the end of the 12-month postpartum period.

Related Policy

Provider Referral Process, A-125
Pregnancy, A-144.5
Medicaid Termination, A-825
Verification Requirements, A-870
How to Determine Spend Down, A-1359
Spend Down EDGs, A-1532.1
Reuse of an Application Form After Denial, B-111
Medicaid Reinstatement, B-530
Current Medicaid, Medicare (Part A or B) and Children's Health Insurance Program (CHIP) recipients, W-911
Pregnant Women, W-912

A-821 Types of Coverage

Revision 15-4; Effective October 1, 2015

Medical Programs

The type of coverage determines how recipients access Medicaid services. There are two types of coverage: fee-for-service and managed care.

A-821.1 Fee-for-Service

Revision 15-4; Effective October 1, 2015

Medical Programs

Fee-for-service, also known as Traditional Medicaid, allows access to any Medicaid provider and self-referral to specialists. The provider submits claims directly to the claims administrator for reimbursement of Medicaid-covered services.

A-821.2 Managed Care

Revision 21-1; Effective January 1, 2021

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, and TP 56

Medicaid managed care is health care provided through a network of doctors, hospitals or other health care providers who contract with a managed care organizations (MCO). The state pays the MCO a capitated rate for each member enrolled, rather than paying for each unit of service. The providers submit claims directly to the MCO for reimbursement of Medicaid-covered services.

Medicaid managed care programs include:

- STAR (State of Texas Access Reform). STAR provides acute care services (like doctor visits, hospital visits and prescriptions), and each member is enrolled in an MCO and assigned a main doctor to coordinate care. People who are dually eligible for Medicare and Medicaid are excluded from this program.
- STAR Health. STAR Health provides comprehensive, coordinated health care services for children in foster care and kinship care. Each member is enrolled with a single MCO, Superior HealthPlan, and is assigned a main doctor to coordinate care. People who are dually eligible are excluded from this program.
- STAR+PLUS. STAR+PLUS provides acute care and long-term services and supports (LTSS). A key feature of this program is service coordination, or specialized care management. Each member is enrolled with an MCO, and Medicaid-only members are assigned a main doctor. STAR+PLUS serves Medicaid-only and dually eligible people, including most nursing facility residents. It is a statewide program.
- STAR Kids. STAR Kids provides acute care services and LTSS. Additionally, people eligible for Medically Dependent Children’s Program (MDCP) waiver services receive these services through STAR Kids. A key feature of this program is service coordination. Each member is enrolled with an MCO and assigned a main doctor to coordinate care. STAR Kids serves children and young adults age 20 or younger with disabilities.

- Children's Medicaid Dental Services. Children's Medicaid Dental Services provide primary and preventive dental services through managed care. Each member is enrolled in a dental maintenance organization (DMO) and has a main dental home. Most children, birth through age 20, who receive Medicaid, are eligible for dental services.

Medicaid managed care is available statewide. Information concerning the medical and dental managed care plans with contact information for each plan is located at Managed Care Organization and Dental Maintenance Organization Provider Services Contact Information.

Texas Works Medicaid recipients must enroll in managed care. **Exceptions (not comprehensive):**

- STAR exceptions:
  - people who are dually eligible for Medicaid and Medicare;
  - children enrolled in the DSHS Children with Special Health Care Needs (CSHCN) Program;
  - children and adults residing in institutions (nursing facilities, Intermediate Care Facilities, and State Supported Living Centers);
  - medically-needy program participants;
  - children in foster care or kinship care;
  - adults that receive SSI; and
  - children and adults that are in a 1915(c) waiver program.
- STAR Health exceptions:
  - youth adjudicated in Texas Juvenile Justice Department (TJJD) facilities;
  - youth from other states placed in Texas, or Texas youth placed in other states; and
  - youth residing in Medicaid-paid facilities.
- STAR+PLUS exceptions:
  - a person 20 or younger who is not in the Medicaid for Breast and Cervical Cancer (MBCC) program;
  - people over the age of 21 in Former Foster Care in Higher Education (FFCHE); and
  - people over 21 who are in a 1915(c) waiver program or who reside in community home for people with Intellectual Developmental Disabilities and are dually eligible for Medicare and Medicaid.
- STAR Kids: A person over the age of 21 and a person 20 or younger without disabilities.
- Children's Medicaid Dental Services exceptions:
  - people 20 or younger who reside in an institution;
  - people in STAR Health;
  - youth placed in other states; and
  - adults 21 and older.

MAXIMUS:

- Contracts with the state to enroll recipients into Medicaid managed care.
- Mails enrollment packets that include information about the plan choices available in their county of residence to newly certified recipients.

If a recipient does not choose a plan or a main doctor by the deadline provided in the enrollment packet, MAXIMUS assigns a plan and a main doctor. They then mail the information to the recipient.

Members of federally recognized Indian tribes are exempt from mandatory enrollment in Medicaid managed care but may choose to participate voluntarily.

At all Medicaid applications and redeterminations, identify and determine if the person qualifies for this exemption. If this information is not available, do not designate the person as exempt. Do not pend the application or delay the eligibility determination for this information.

TIERS refers newly certified recipients to MAXIMUS to initiate their enrollment into managed care. MAXIMUS staff is available in some local eligibility determination offices. A recipient can call the MAXIMUS Helpline at 800-964-2777 to initiate enrollment, to request a plan change, or to disenroll from managed care if they are exempt from mandatory enrollment in Medicaid managed care.

If a recipient has difficulty accessing medical services in a managed care plan, refer the person to the Medicaid Managed Care Helpline at 866-566-8989. The Medicaid Managed Care Helpline advocates for managed care recipients who are having trouble accessing the medical and dental care they need.

Related Policy

Office of the Ombudsman, B-1420
Managed Care Plans, C-1116

A-822 Medicaid Coverage for New State Residents

Revision 15-4; Effective October 1, 2015

Medical Programs

Advisors must determine the correct MED for applicants who:

- move to Texas from another state during the application month or the three months prior to the application month, and
- are Medicaid recipients in the losing state in the month they move.

Step	Action
1	If the losing state denied the recipient's Medicaid the last day of the month the recipient moved from the state or later, then go to Step 2. If the losing state denied the recipient's Medicaid the day the recipient moved from the state, then assign an MED = date the applicant became a Texas resident.
2	Did any member of the certified group incur Medicaid-reimbursable bills after they moved to Texas? If **yes**, then verify the effective date of denial in the losing state. Go to Step 3. If **no**, then verify the effective date of denial in the losing state. Assign an MED = first day of the month after the month the losing state denied the recipient's Medicaid.
3	Will the losing state pay for the bills incurred in Texas after the day the person became a Texas resident? If **yes**, then assign an MED = first day of the month after the month the losing state denied the recipient's Medicaid. If **no**, then assign an MED = date the applicant became a Texas resident.

Note: If the applicant is unable to provide a contact person in the losing state, the advisor must contact the appropriate state Medicaid director's office. See C-1111, State Medicaid Agencies, for telephone numbers.

When a Texas Medicaid recipient moves to another state, staff from the gaining state may contact the local office about effective dates of denial and coverage of bills incurred in the gaining state. Texas Medicaid pays for Medicaid-reimbursable services provided out-of-state if the:

- recipient needs services because of a medical emergency documented by the attending physician or other provider;
- recipient's health could be jeopardized by not obtaining services; and
- provider enrolls in the Texas Medicaid Program. Out-of-state providers can obtain enrollment information by calling the claims administrator at 1-800-925-9126.

A-823 Lock-In Status

Revision 26-3; Effective July 1, 2026

Medical Programs

HHSC identifies fee-for-service and managed care people who:

- received duplicative, excessive, contraindicated or conflicting health services, including drugs; or
- abused, misused or committed fraudulent actions related to Medicaid benefits and services.

These people may choose one pharmacy and one main doctor to be their designated provider for Medicaid services.

The duration periods of lock-in status are:

- The initial period is 36 months.
- The second period is 60 more months.
- The third period is for the extent of eligibility and all later periods of eligibility.
- The period of lock-in status for people arrested, indicted, convicted or admitting to a crime about Medicaid fraud differs from the first, second and third lock-in periods. These people are assigned lock-in status for:
  - 60 months; or
  - the length of eligibility and later periods of eligibility up to or equal to 60 months.

HHSC issues a Your Texas Benefits Medicaid card printed with the name of the Lock-in Doctor, Lock-in Drug Store or both on the front of the card for people with enrollment lock-in status. If a person with lock-in status prints a Medicaid card from the YourTexasBenefits.com, the same information is displayed.

Staff must verify current lock-in status when issuing Form H1027-A, Medicaid Eligibility Verification. To verify a person's lock-in status, staff may access the person's **Lock-In Enrollment** page from the **Individual – Summary** page's hover menu. If a person is in lock-in status, the **Lock-In Enrollment** page displays the provider name and begin date of the status.

People are removed from lock-in status at the end of the specified period if their use of medical services no longer meets the criteria for lock-in status.

Refer people with questions about their lock-in status to the:

- HHS Office of Inspector General (OIG) using the HHS Lock-In Program mailbox for people receiving fee-for-service.
- Managed care organization for people who receive managed care.

A-824 Issuance of Form H1027-A, Medicaid Eligibility Verification

Revision 15-4; Effective October 1, 2015

Medical Programs

Advisors must issue Form H1027-A, Medicaid Eligibility Verification, to an eligible Medicaid individual only if the individual:

- needs his eligibility verified to receive medical services;
- does not have access to a Your Texas Benefits Medicaid card; and
- is unable to reprint the Medicaid card from YourTexasBenefits.com.

The individual may not have a Your Texas Benefits Medicaid card if the individual:

- is newly certified and has not received it,
- lost or accidentally destroyed the card, or
- is temporarily separated from other eligible family members who have their card.

Before issuing Form H1027-A, staff must verify the individual's current eligibility, enrollment lock-in status and managed care enrollment by accessing the Individual – Summary and Individual – Medicaid History pages. If inquiry is unavailable, advisors must follow regional procedures.

Medicaid with No Enrollment Lock-in or Managed Care Coverage

Issue Form H1027-A for current eligibility if the most recent medical coverage period on the Individual – Summary and Individual – Medicaid History pages:

- is open (no close date shown), and
- reflects regular Medicaid coverage.

Enrollment Lock-in

If an individual is in enrollment lock-in status, "Yes" will display after Lock-In on the **Individual – Summary** page. Advisors select **Lock-In Enrollment** from the hover menu over the individual's client number. The **Individual – Lock-In Enrollment** page provides information regarding the provider(s) to which the individual is currently or was once locked in.

If an individual is currently in lock-in, advisors issue a separate Form H1027-A for the individual and print LIMITED and the name(s) of the provider(s) to which the individual is locked in. Form H1027-A generated in TIERS is printed with "LIMITED" in the "Type of Coverage" field.

Managed Care Coverage

If an individual is in a managed care service area, "Yes" will display after Managed Care on the Individual – Summary page. Select **Managed Care** from the hover menu over the individual's client number. Advisors select the Individual – Managed Care page to view the individual's plan to which the individual is enrolled.

Advisors must issue Form H1027-A for everyone on the case in the same managed care plan by printing the appropriate managed care program name (e.g., STAR, STAR Health, STAR+PLUS) and the name and telephone number of the plan. This information is in C-1116, Managed Care Plans.

After staff verify eligibility, enrollment lock-in status and managed care enrollment, advisors complete, sign and date Form H1027-A. The unit supervisor or other second party must approve the form indicating he verified eligibility and lock-in status.

Form H1027-A is not used if the most recent medical period:

- is closed, or
- shows institutional coverage.

Form H1027-A instructions include detailed information for completing the form.

TA 74, TA 75, TA 76, TA 83, TA 86 and TP 42

The advisor must issue Form H1027-A if the person has a completed Form H1266, Short-term Medicaid Notice - Approved, showing the date the person is approved for coverage.

Form H1027-A instructions include detailed information for completing the form.

State Paid Medicaid

TA 62

State Paid Medicaid coverage shows in the Medicaid History screen when the individual was not eligible for Medicaid and staff have issued Form H1027-A in error. State Paid Medicaid is 100 percent state-funded.

A-825 Medicaid Termination

Revision 26-1; Effective Jan. 1, 2026

TP 08

If an application is not received by the last day of the month, an EDG is automatically denied effective the last day of the last benefit month.

Related Policy

Denial at Redetermination, A-2342

Emergency Medicaid

Eligibility for Emergency Medicaid ends the date the person's medical condition is stabilized as verified by the attending practitioner or other practitioner familiar with the patient's condition. Verification is done on Form H3038, Emergency Medical Services Certification, or Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification.

TP 33, TP 34, TP 35

A child under 19 certified for Emergency Medicaid receives Emergency Medicaid coverage for a continuous 12-month certification period.

TP 36

A woman certified for Medicaid for Pregnant Women – Emergency (TP 36) receives Emergency Medicaid coverage through the pregnancy and the 12-month postpartum period. Only services needed to stabilize the patient’s condition during the emergency or life-threatening situation are covered. Services provided after the initial emergency condition becomes stable are not covered.

Note: TP 36 recipients do not have to submit another Form H3038 or Form H3038-P during the 12-month postpartum period for any later emergency events. Do not process the TP 36 certification as an open and close segment. The eligibility determination system automatically provides the 12-month certification and postpartum period.

Certify the recipient for CHIP-P, if eligible if the TP 36 recipient submits a change or new application reporting a new pregnancy during the 12-month postpartum period and maintain the current TP 36 12-month postpartum period. The eligibility determination system also creates a new EDG for the new postpartum period.

Note: Households with income at or below 198% of the Federal Poverty Limit (FPL) can receive concurrent CHIP-P and TP 36 coverage. CHIP-P coverage ends on the last day of the pregnancy termination month, while TP 36 coverage continues through the end of the 12-month postpartum period.

Related Policy

Regular Medicaid Coverage, A-820

TP 40

Medicaid eligibility for a pregnant woman ends on the last day of the 12th month after the month the pregnancy terminates, regardless of how the pregnancy ends. If the pregnancy ends in a month later than expected, change the end date to reflect the new termination date.

A woman whose Medicaid for Pregnant Women coverage ends is automatically tested for other types of medical assistance. Use the current case information without requiring a new application, if the EDG was not denied for the following reasons:

- voluntary withdrawal;
- death;
- move out of Texas;
- determined ineligible due to agency error, fraud, abuse or perjury attributed to the person;

- receipt of benefits in another group; or
- failure to provide postponed verification.

The eligibility determination system automatically determines the woman's eligibility for another type of medical assistance. If eligible, the woman receives a new certification period after the current TP 40 coverage ends.

TP 32, TP 36, TP 40, and TP 56

A woman certified on the day her pregnancy ends is eligible to receive the same type of Medicaid for a 12-month postpartum period after her pregnancy ends.

Once certified for Medicaid for Pregnant Women– Emergency (TP 36), a woman is eligible to receive TP 36 through the pregnancy and 12-month postpartum period. A woman certified for Medically Needy with Spend Down (TP 32 and TP 56) is eligible to receive TP 32 or TP 56 through the pregnancy and the 12-month postpartum period. She does not have to meet the spend down amount again. The original budget used to certify the Medicaid coverage on the day the woman's pregnancy ends is the same budget used for the 12-month postpartum period.

Related Policy

How to Determine Spend Down, A-1359
Denial of an Application, A-2341
Denial at Redetermination, A-2342

TP 43, TP 44 and TP 48

A child is continuously eligible for a 12-month certification period. If a household fails to report required information at application causing a child to be ineligible for Medicaid, deny the EDG and send a fraud referral to the Office of the Inspector General (OIG). This does not apply if the household provides verification required by policy.

Example: The household applies for Medicaid for a child, provides one pay stub, and is determined eligible. If providing more income verification would result in the child being ineligible, do not deny the Medicaid EDG. The child remains continuously eligible for the 12-month certification period, because policy requires only one pay stub or most recent tax return to verify income for a child's Medicaid EDG.

EDGs with end dates do not require staff action to close the EDG when the household does not return a renewal form. These will close effective the last day of the last benefit month of the certification period.

Note: Independent children living in state hospitals are continuously eligible for a 12-month certification period, even if the child is released from the state hospital. If a child is released from the facility before the end of the 12-month certification period, process the address change and continue coverage.

A child is eligible through the last day of the month of the child's:

- first birthday for TP 43;
- sixth birthday for TP 48; and
- 19th birthday for TP 44.

When a child ages out of the current type of assistance during the continuous eligibility period, the eligibility determination system sustains the TP 43 or TP 48 EDG for the rest of the 12-month certification period.

The child is tested for CHIP eligibility at redetermination, if the MAGI is more than the FPL for the next type program. If ineligible for CHIP, the child is referred to the Federally Facilitated Marketplace (FFM).

Exception: Children aging out of TP 44 are eligible through the last day of the month they turn 19.

If a child is ineligible for another type of assistance or turns 19, the child may continue to receive Medicaid if the child:

- is hospitalized on the child's 19th birthday;
- remains hospitalized without a time limit; and
- meets all eligibility requirements except age.

Verify the child's hospitalization and update the child's living arrangement to hospital to prevent the eligibility determination system from denying the child's coverage.

Verify the hospitalization each month and update the child's living arrangement when the hospitalization ends.

Related Policy

Continuous Medicaid Coverage, A-832
Medical Programs Administrative Renewals, B-122.4
Processing Children's Medicaid Redeterminations, B-123

TP 45

A child's eligibility terminates the last day of the month of the child's first birthday. Deny the TP 45 EDG before the child's first birthday if the:

- child's mother was presumptively eligible;
- received TP 42 and was not eligible for regular Medicaid at the time of the child's birth; and
- the child is eligible for TP 45 through the end of the birth month; or
- child no longer lives in Texas. The child is eligible for TP 45 through the month the change occurs.

Notes:

- If the child's mother met spend down and received TP 56 or TP 32 to cover the child's birth, the child is eligible for TP 45 from the date of birth until the end of the month the child turns one.
- Data Integrity (DI) ends the newborn's coverage before the child's first birthday in situations that the child's mother relinquishes her parental rights and information about the child's current residency and new caretaker is unknown.

Related Policy

TP 45 Provider Referral Process, A-125
Regular Medicaid Coverage, A-820

A-825.1 Recipients of TANF and TP 08

Revision 17-2; Effective April 1, 2017

Recipients of TANF must comply with the Personal Responsibility Agreement (PRA), including cooperating with child support requirements and participating in the Choices program, unless exempt. TP 08 coverage is terminated if an individual receiving both TP 08 and TANF is sanctioned for failure to comply with the Choices PRA requirements.

Individuals certified for TP 08, but not TANF, must cooperate with medical support requirements. Failure to cooperate with the requirements result in the termination of the individual's TP 08 coverage.

Notes:

- TANF sanctions due to noncooperation with other PRA requirements do not result in termination of TP 08 coverage.
- Individuals receiving TP 08 who are not receiving TANF are not required to comply with the TANF PRA.
- The noncooperating adult may reapply for Medicaid and qualify after the identified forfeit months, with the exception of those who non-comply with child support. These individuals must comply before becoming eligible for Medicaid.

Related Policy

Sanctions for Noncooperation, A-1141
Personal Responsibility Agreement, A-2100
Choices, A-2121
Child Support, A-2122
When to Start a Full-Family Sanction, A-2141
Denial at Redetermination, A-2342

A-826 Reserved for Future Use

Revision 20-4; Effective October 1, 2020

A-827 Your Texas Benefits Medicaid Card

Revision 19-4; Effective October 1, 2019

Medical Programs

When a person is certified for ongoing Medicaid benefits, a Your Texas Benefits Medicaid card is mailed, which should:

- be carried and protected like a driver's license or credit card; and
- used when visiting a Medicaid provider (i.e., doctor, dentist or pharmacy).

The Your Texas Benefits Medicaid card is plastic, like a credit card, and includes the following information printed on the front:

- person's name and Medicaid ID number;

- managed care program name (if STAR Health);
- date the card was issued; and
- billing information for pharmacies.

The back of the card includes the statewide toll-free phone number where people can get more information about the Your Texas Benefits Medicaid card.

Each person certified for Medicaid in a household receives one Your Texas Benefits Medicaid card. It is intended to be the person's permanent card.

If a person loses:

- Medicaid coverage but later regains coverage, the person can use the same Your Texas Benefits Medicaid card.
- Their Your Texas Benefits Medicaid card, they can request a replacement by:
  - logging on to their YourTexasBenefits.com account;
  - calling 2-1-1 (after selecting language, select Option 2, and then Option 1); or
  - calling 855-827-3748.

If a person forgets their Your Texas Benefits Medicaid card, a provider (i.e., doctor, dentist or pharmacy) can verify Medicaid coverage by:

- calling the TMHP Contact Center at **800-925-9126**; or
- visiting the Texas Medicaid and Healthcare Partnership's (TMHP's) TexMedConnect website using the person's Medicaid ID number or one of the following combinations for the person:
  - Social Security Number (SSN) and last name;
  - SSN and date of birth (DOB); or
  - last name, first name, and DOB.

If a person needs quick proof of eligibility, they can;

- log in to their www.YourTexasBenefits.com account to print a temporary card; or
- go to a local benefits office to request a card. HHSC staff in the office will:
  - assist the person accessing and printing a Medicaid card from the person's www.YourTexasBenefits.com account from the office's lobby computer; or
  - generate a temporary Form H1027-A, Medicaid Eligibility Verification, via TIERS if the person prefers not to or has trouble accessing their Medicaid card online.

A-830, Medicaid Coverage for the Months Prior to the Month of Application

Body

Revision 13-2; Effective April 1, 2013

A—831 Three Months Prior Coverage

Revision 15-4; Effective October 1, 2015

Medical Programs except TP 40

Applicants may be eligible for Medicaid coverage during the three-month period before the month they apply for Medical Programs. Prior coverage may be continuous or there may be interrupted periods of eligibility involving all or some of the certified members.

TP 40

Medicaid for a pregnant woman does not begin before the first day of the month her pregnancy began, as explained in A-820, Regular Medicaid Coverage.

A—831.1 How to Apply for Three Months Prior Coverage

Revision 15-4; Effective October 1, 2015

Medical Programs except TP 45

A person applies for three months prior Medicaid coverage by completing Form H1113, Application for Prior Medicaid Coverage. Advisors must give this form to applicants who indicate on an application or during the application interview that the family has unpaid medical bills incurred during the three months before the application month. **Exception**: For Children's Medicaid, Form H1113 is not required if the family provides enough information to determine eligibility for prior months.

Related Policy

Continuous Medicaid Coverage, A-832
TP 45 Retroactive Coverage, A-833

A—831.2 Eligibility for Three Months Prior Coverage

Revision 17-1; Effective January 1, 2017

Medical Programs except TP 40

Advisors certify the applicant for Medicaid only for the month(s) the individual meets all eligibility requirements and has:

- unpaid medical bills for Title XIX-covered services; or
- received Medicaid services from the Texas Department of State Health Services.

Advisors provide prior Medicaid coverage even if the:

- family is not currently eligible for Medical Programs; or
- person with unpaid medical bills is deceased.

TP 08

Certify a parent or caretaker relative for a prior month(s) if they are caring for a dependent child who meets all eligibility requirements in the prior month(s), but is not certified for Medicaid in the prior month(s) because the child does not have unpaid medical bills.

TP 40

Gaps do not apply to TP 40. Once eligibility is determined in one of the prior months, it continues even if there are no unpaid medical bills in a subsequent prior month.

A—831.2.1 Reopening Three Months Prior Applications

Revision 21-3; Effective July 1, 2021

Medical Programs

Applications for prior Medicaid coverage may be reopened for one or more month(s) in the three-month prior period when:

- the person requests the application be reopened within two years after the application file date; and
- Medicaid eligibility (certification with or without spend down) for the person or month(s) of coverage requested was not previously established.

Verify a previous application was filed. Use any application filed by the household within the past two years as a basis for determining eligibility for prior Medicaid coverage, even if the application did not request ongoing Medicaid, prior months' Medicaid coverage or claim unpaid medical bills. Medicaid eligibility can only be established within two years after the application file date whether or not the request was processed due to agency or applicant error.

Note: Do not reopen an application for prior Medicaid for a month that Medicaid eligibility (certification with or without spend down) was established, even if the spend down was closed by the Clearinghouse.

A—831.3 Income Computation

Revision 15-4; Effective October 1, 2015

Medical Programs

Staff must determine eligibility for each month in which there are unpaid medical bills using the income and verification rules explained in A-1300, Income

The needs and income of people who would have been considered in the client's MAGI household composition for each month the client's MAGI household composition has unpaid medical bills are included.

A—831.4 Determining the Appropriate Type Program for the Prior Month

Revision 15-4; Effective October 1, 2015

Medical Programs

Use the following chart to determine the type program to use for eligibility in the prior month:

If the type program is …	and the modified adjusted gross income for the prior month is …	then …
TP 08,	less than or equal to the FPIL amount for TP 08 and there is no gap in coverage,	certify the application for the prior month.
TP 08,	less than or equal to the FPIL amount for TP 08 and: • there is a gap in coverage, or • the individual is not currently eligible,	certify the application for the prior month(s).
TP 08,	more than the FPIL amount for TP 08,	do not certify the application for the prior month in this type program. Check eligibility for another type program.
TP 40, TP 43, TP 44, or TP 48,	less than or equal to the FPIL amount for that program,	certify the application for the prior month.
TP 40, TP 43, TP 44, or TP 48,	more than the FPIL amount for that program,	do not certify the application for the prior month in this type program. Check eligibility for TP 56.
TP 45,	not applicable,	these applicants are always eligible back to the date of birth.
TP 56,	more than the medically needy income limit (MNIL),	determine if the household has enough medical expenses to meet spend down for the prior month. If **yes**, then certify the children or pregnant woman. If **no**, then deny the application for prior coverage.
TA 31, TP 33, TP 34, TP 35, or TP 36,	less than or equal to the FPIL amount for that program,	certify the applicant for the prior month only for the dates of the emergency medical condition verified on Form H3038, Emergency Medical Services Certification, or Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification.
TP 32	above the income limits as stated above (applies only to children [under age 19] and pregnant women),	determine if the household has enough medical expenses to meet spend down for the prior month. If **yes**, then certify the child or pregnant woman. If **no**, then deny the application for prior coverage.

Note: Applicants are considered for eligibility in Medicaid for Former Foster Care Children (TA 82) and Medicaid for Transitioning Foster Care Youth (TP 70) before TP 08.

A—831.5 Medical Eligibility Date for Three Months Prior Coverage

Revision 13-2; Effective April 1, 2013

Medical Programs

The MED for a month of prior coverage begins the earliest day in the month the individual met all eligibility criteria. It is the first day of the month unless all eligibility criteria were not met.

Related Policy

Regular Medicaid Coverage, A-820

A—831.6 Applications Based on Incapacity

Revision 15-4; Effective October 1, 2015

TP 08 and TA 31

If the applicant claiming incapacity meets the other eligibility requirements for prior Medicaid coverage, the advisor must document information according to A-1080, Disability Verification.

A—832 Continuous Medicaid Coverage

Revision 25-1; Effective Jan. 1, 2025

TP 40

Provide continuous Medicaid coverage without an application or an interview for a pregnant woman. Coverage is provided through the 12th month after the pregnancy ends regardless of any changes if she:

- received Medicaid on a program other than TP 40 and was ineligible because of income;
- provides verification that she was pregnant in the month she becomes ineligible for Medicaid; and
- received Medicaid within 11 months before the application month.

After determining a pregnant woman is eligible for TP 40, the woman remains eligible regardless of any changes unless she:

- voluntary withdraws;
- moves out of state;
- is ineligible due to agency error, fraud, abuse or perjury attributed to the person; or
- dies.

Note: Accept the pregnant woman's, head of household or AR's verbal or written statement of pregnancy as verification. A statement must include the name of the woman who is pregnant, pregnancy start month, number of expected children, and anticipated delivery date. The person may also provide Form H3037, Report of Pregnancy, or another document with information specified on Form H3037.

Provide continuous Medicaid coverage to a pregnant woman denied with an administrative denial reason such as failure to keep appointment and voluntary withdrawal, if her Medicaid would have been denied because of income if the income had been reported.

The continuous coverage policy applies to women who were receiving benefits from the following programs:

- SSI, MEPD, DFPS or MBCC.
  - When an SSI Medicaid recipient is denied, the eligibility determination system sends Form H1296, Notice of SSI Medicaid Ending, informing the recipient that she may be potentially eligible for other Medical Programs within HHSC.
- When a recipient's SSI, MEPD, DFPS or MBCC coverage is denied during a woman's pregnancy or if she is within her 12-month postpartum period, provide continuous TP 40 coverage through the rest of her pregnancy and postpartum period.
- A caretaker certified on TP 08 who is not eligible for TP 07 or TP 20.
- A caretaker or child certified on TP 07 or TP 20.
- A child certified on TP 44.

A child under 19 determined eligible and certified for TP 40 receives continuous eligibility through her pregnancy and 12-month postpartum period even if the child turns 19 before the end of the 12-month postpartum period.

TP 43, TP 44 and TP 48

A child under 19 receives a 12-month certification period. The child is continuously eligible for Medicaid for 12 months or through the month of the child's 19th birthday, whichever is earlier.

Exceptions to continuous eligibility include:

- death;

- moves out of state;
- voluntary withdrawal;
- certified in error;
- renewal of eligibility due to agency error or fraud, abuse, or perjury attributed to the child or AR and HHSC's Office of Inspector General (OIG) determined the person fraudulently received Medicaid and coverage should be denied;
- reaches 19;
- if a household reports that a sibling has moved into the household, requests Medicaid for the sibling and the sibling is added to the current case, the new Medicaid-eligible child's certification period is aligned with the end of the existing child's certification period;
- the household failed to report required information at application that causes the child's ineligibility for Medicaid; or
- child enters a secured juvenile facility.

If the household is eligible in the application month, process month, or ongoing month, the child is eligible for 12-months of continuous coverage. This begins the first month the household meets the eligibility criteria. **Note:** This includes situations where the household is eligible in the application or process month, but not in an ongoing month.

If the household is eligible only in a month before the application month, certify the child only for the prior month or months they are eligible for.

Note: Explore TP 56 for the child if the person indicates the child has unpaid bills in a month of ineligibility.

Related Policy

Medicaid Termination, A-825
What to Report, B-621

A—833 TP 45 Retroactive Coverage

Revision 15-4; Effective October 1, 2015

TP 45

Advisors must provide retroactive TP 45 coverage for newborn children without requiring an application or an interview with the child's mother if all of the following conditions are met:

- There are unpaid Title XIX bills for the newborn child.
- The mother of the child is unwilling, unable or refuses to apply for current benefits for the child, or the child is not eligible for current benefits.
- The advisor has verification of the following eligibility factors for the newborn child:

Eligibility Factor	Eligibility Requirement
Age	Coverage must be initiated within one year of the child's birth. The child's coverage cannot continue after the child becomes 13 months old.
Residence	Child must be residing in Texas.
Natural mother's Medicaid coverage dates	Child's mother must be eligible for and receiving Medicaid on the day the child is born. The mother's eligibility can be determined retroactively. See A-820, Regular Medicaid Coverage.

The file date is the day the advisor is notified about the unpaid bills for the child.

TIERS will allow a:

- file date as late as the month of the child's first birthday, and
- medical effective date as early as the child's date of birth.

A—834 Retroactive Medicaid Coverage for Abandoned Children

Revision 18-1; Effective January 1, 2018

Medical Programs

If a newborn or child is abandoned at an acute care hospital, or at a psychiatric hospital while receiving inpatient services, DFPS requests a court order for custody. Once the court order is obtained, DFPS provides Medicaid coverage from the day in which custody is granted. The MED is the date DFPS takes conservatorship. This may result in the newborn or child having unpaid medical bills if DFPS takes conservatorship after the date of birth or the date of admission to the hospital and the date DFPS takes conservatorship.

A designated DFPS representative completes Form H1113, Application for Prior Medicaid Coverage, requesting coverage on behalf of the abandoned child and forwards the request to a designated Texas Works advisor within Centralized Benefit Services (CBS) at cbs_ffche-mtfcy@hhsc.state.tx.us.

For children abandoned in a psychiatric hospital, DFPS will only submit applications to request retroactive Medicaid for a child receiving inpatient treatment.

CBS advisors provide retroactive Medicaid coverage only during the following situations:

- A newborn is taken into foster care conservatorship after the date of birth but before the child is released from the hospital, creating a gap in coverage from the date of birth through the day before the foster care conservatorship date.
- A child of any age is taken into foster care conservatorship while in the hospital, but after the admission date, creating a gap in coverage from the date of admission to the day before the foster care conservatorship date.

Note: The MED for a child (not a newborn) cannot precede the date of admission into the hospital.

A-840, Transitional Medicaid Coverage

Body

Revision 02-6; Effective July 1, 2002

A-841 General Eligibility Information

Revision 26-2; Effective April 1, 2026

TP 07

Some TP 08 household members may be eligible for Earnings Transitional Medicaid, TP 07.

TP 07 eligibility is based on if a parent or caretaker relative is certified for TP 08, Parents and Caretaker Relatives Medicaid, in Texas for three of the six months before the first month of ineligibility. If a TP 08 recipient's coverage is eligible for Transitional Medicaid, their children will also be eligible. Each person is certified on an individual Transitional Medicaid EDG for the length of the certification period.

Example: The household composition includes a mother, father, and two mutual children. The mother and father are each certified on an individual TP 08 EDG in Texas for three of the six months before the month of ineligibility. Each child is on an individual Children's Medicaid EDG. The father's income increases making him ineligible for TP 08. The father is then certified on an individual TP 07 EDG. The mother and the two children are certified on individual TP 07 EDGs. Each has the same certification period as the father.

When a TP 07 EDG is created, other eligible household members receive a new TP 07 EDG with the same certification period.

Exception: A household member is not eligible for TP 07 if the recipient was ineligible for TP 08 because they committed fraud during any of the six months before the TP 07 EDG was opened. Fraud must be determined by a court or through a hearing. If the TP 07 EDG was opened before the fraud determination was known:

- the recipient is disqualified using advance adverse action notice procedures; and
- notify transitional child care staff that the member should not have received transitional benefits because of Medicaid fraud.

TP 08 households denied for any reason may request TP 07 during the adverse action time frame and have their eligibility re-determined.

Applicants may request TP 08 any time after denial. These individuals and their household members may also request TP 07 if they become employed.

The number of months of TP 07 coverage is 12 months.

Related Policy

Parents and Caretaker Relatives Enter or Already Live in the Home, A-846.1
Child Enters or Already Lives in the Home, A-846.2
Action in Full Service Choices Counties or E&T Counties, A-1831

Action in Minimum Service Choices Counties or Non-E&T Counties, A-1832
State Time Limits, General Policy, A-2510

A-841.1 Multiple Changes That Cause TP 08 Ineligibility

Revision 15-4; Effective October 1, 2015

TP 08

If two or more changes (when one is new or increased earned income) cause the income to increase from less than the FPIL for TP 08 to more than the FPIL for TP 08 for the same month, and the household has not been notified that members are eligible for TP 07, advisors follow the steps below:

Step	Action
1	If all other case factors remain the same, is the household income increased to above the FPIL for TP 08 because of new or increased earnings? • **Yes**. The family is eligible for TP 07 if members meet the other eligibility requirements. • **No**. Go to Step 2.
2	Is the income increased to above the FPIL for TP 08 as a result of a change other than new or increased earnings? • **Yes**. The family is not eligible for TP 07. Go to Step 3. • **No**. Go to Step 4.
3	Does the family meet the income limits for the Medical Program EDGs for which they are certified? • **Yes**. Continue current Medical Program coverage. • **No**. Deny the Medical Program EDG(s) for which the individual is no longer income eligible.
4	Is the income increased to above the FPIL for TP 08 when all changes are considered? **Yes**. The family is eligible for TP 07 if the members meet the other eligibility requirements.

Changes reported in a timely manner do not stop the denial of the TP 08 EDG and creation of the TP 07 after the household is notified of transitional Medicaid eligibility, even when both changes affect the same month.

Exceptions: The EDG is denied if the household:

- moves out of Texas;
- no longer meets the household composition requirement as specified in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage; or
- reports a change that makes the household ineligible before the first month of transitional Medicaid eligibility.

A-841.2 Notice to Clients

Revision 15-4; Effective October 1, 2015

TP 08

When TIERS denies a TP 08 EDG and creates a TP 07, TIERS generates Form TF0001, Notice of Case Action, to notify the household:

- that their TP 08 and their children on associated TP 43, TP 44 and TP 48 EDGs are denied;
- the date their TP 07 benefits will end; and
- about the transitional Medicaid eligibility and reporting requirements. **Note**: If the individual is in the office, the advisor may explain the reporting requirements.

A-841.3 Eligibility Criteria During Transitional Medicaid Coverage

Revision 15-4; Effective October 1, 2015

TP 07

Certified members remain eligible for transitional Medicaid if the:

- household continues to live in Texas, and
- EDG meets one of the following household composition requirements.

The transitional EDG includes an eligible child.

Note: For transitional Medicaid, an eligible child is a child who meets all of the following requirements:

- citizenship,
- Social Security number (SSN),
- age,
- relationship, and
- domicile.

OR

A parent or caretaker relative cares for a child who receives:

- SSI;
- adoption assistance payments; or
- federal, state or local foster care payments; or
- Medicaid (TP 07, 20, 40, 43, 44, 45, or 48.

The noncomplying adult who is certified for TP 07 is denied when the advisor receives notice that the legal parent failed to cooperate with third-party resource (TPR) requirements or has been found guilty of a Medicaid intentional program violation.

If another-related caretaker failed to cooperate with TPR requirements or was found guilty of a Medicaid intentional program violation, the advisor must:

- change the status to payee, or
- deny the transitional Medicaid EDG if the other-related caretaker is the only person on the EDG.

The advisor must not:

- count unearned income of household members when determining continued eligibility for households certified for transitional Medicaid; or
- deny a transitional Medicaid EDG because of new or increased income of a household member, unless reported in the seventh or tenth month Medicaid Status Report.

A-842 TP 07 Transitional Medicaid

Revision 15-4; Effective October 1, 2015

TP 08

TP 08 certified members are eligible for TP 07 if:

- at least one of the group members was eligible for and received TP 08 in Texas for three of the six months before the first month of ineligibility; and
- the denial is because:
  - a certified parent, certified caretaker relative, or disqualified legal parent began receiving or had an increase in gross earned income; or
  - of the earnings of a new or returning absent parent who is added to the certified group because the household meets incapacity or deprivation criteria.

A-842.1 Determining the First Month of TP 07 Medicaid

Revision 15-4; Effective October 1, 2015

TP 08

The first TP 07 month is the month the change is effective (when reported and acted on timely) when new or increased earnings cause a certified parent or caretaker relative on TP 08 to be over the FPIL for TP 08.

Determine the first month of TP 07 eligibility using the following chart:

Step	Action
1	The first month of TP 07 is the first month after adverse action expires when the change is reported, verified, and processed timely (or should have expired if the change was not reported, verified, or processed timely).

Step	Action
	Note: The first month can be no later than the first month of overpayment as described in B-752.1.2, Errors After Certification, but may be earlier based on the date the notice of adverse action expires (as described in A-2343.1, How to Take Adverse Action if Advance Notice Is Required).
2	Was at least one household member eligible for and did that member receive TP 08 in Texas for at least three of the six months prior to the month identified in Step 1? (See A-842.2, Determining the Three of Six Months Eligibility Requirement.) If yes, continue to Step 3. If no, deny the EDG.
3	Designate the month from Step 1 as the first month of TP 07 eligibility.

Individuals who appeal the advisor's decision to deny the TP 08 EDG often receive TP 08 while the appeal is pending. If the hearing officer sustains the advisor's decision, the months the client received continued benefits during the appeal process are counted as TP 07 months.

A-842.2 Determining the Three of Six Months Eligibility Requirement

Revision 20-1; Effective January 1, 2020

TP 08

Advisors must determine whether at least one household member was eligible for and received TP 08 in Texas for three of the six months before the first month of ineligibility.

Advisors must **count** any month when at least one household member was eligible for and received benefits. Advisors must include any month that someone in the household received TP 08.

Advisors must **not count** any month benefits were:

- issued but the household was not eligible;
- not issued;
- received in another state;
- prior Medicaid coverage; or
- Medicaid only for the application month due to certification in a later month.

TP 08 with Other Household Members on a Medical Program

Advisors must determine whether at least one TP 08 household member was eligible for and received Medicaid in Texas for three of the six months before the first month the income increase is effective.

Advisors must **count** any month when at least one household member was eligible for and received Medicaid through:

- TP 08, TP 20, TP 40, TP 43, TP 44, TP 45, TP 48, or TP 56 and spend down was met;
- SSI, including SSI Medicaid only;
- federal, state, or local foster care; or
- adoption assistance.

Advisors must **not count** any months Medicaid benefits were:

- certified but the household member was not eligible;
- received in another state; or
- prior Medicaid benefits.

A-842.3 Automatic Denial of TP 07

Revision 15-4; Effective October 1, 2015

TP 07

Recipients terminated from TP 07 must be retested for eligibility for any other Medical Programs, as explained in A-2342.1, Retesting Eligibility.

A-843 Reserved for Future Use

Revision 20-2; Effective April 1, 2020

A-844 Transitional Medicaid Reporting Requirements for TP 07

Revision 15-4; Effective October 1, 2015

TP 07

Individuals receiving TP 07 coverage are required to report the following changes during the 4th, 7th and 10th months of the transitional period:

- Changes in the household members' gross monthly earnings, and
- Changes in the household composition.

Form H1146, Medicaid Report, is computer-generated and is sent to the household at cutoff in the 3rd, 6th and 9th months. Form H1146:

- informs the household of the availability of continuing transitional coverage,
- provides information about the change reporting requirements, and
- provides a way to report the required information.

Advisors use Form H1146-M, Medicaid Report (Manual), to replace TIERS-generated forms that the household reports are lost or destroyed.

Advisors must not require verification for the transitional Medicaid EDG. **Exception**: Advisors must require appropriate verifications to determine whether a new household member is eligible to be added to the EDG. See A-846.1, Parents and Caretaker Relatives Enter or Already Live in the Home, and A-846.2, Child Enters or Already Lives in the Home.

Note: If the household does not return Form H1146, no action is required.

A-844.1 Staff Action on the Fourth Month Medicaid Report

Revision 21-1; Effective January 1, 2021

TP 07

Use the following procedures to process Form H1146-M, Medicaid Report (Manual), for the fourth month. Take action on the household members' other EDGs and cases if the reported information affects those benefits.

If the household returns Form H1146 and Form H1146 indicates …	then …
the household still meets the household composition requirements in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage,	take no action on the transitional Medicaid case.
a child who is **not** receiving TP 43, TP 44, TP 45, TP 48, or transitional Medicaid is in the home,	see A-846.2, Child Enters or Already Lives in the Home.
a child left the home,	see A-846.3, Household Member Leaves the Home.
a returning absent parent or stepparent,	see A-846.1, Parents and Caretaker Relatives Enter or Already Live in the Home.
a household member certified for TP 07 reports a pregnancy,	explore TP40 eligibility for the pregnant household member.
the household no longer meets the household composition requirements in A-841.3,	• deny the EDG, and • send Form TF0001, Notice of Case Action.
• there are no earnings by the parent or caretaker relative in at least one of the three report months, and there is no good cause for the lack of earnings; or • the average monthly gross earnings of the household members* exceeds the applicable income limit for the household size,	shorten the transitional Medicaid coverage to end after the sixth month. **Note:** If the medical coverage is shortened because the parent or caretaker relative did not have earnings for a complete month, inform the household that they can show good cause. They must show good cause within 13 days. (See A-844.4, Good Cause Determinations.)

* See A-844.3, 185% FPIL Test, for budgeting policies.

Related Policy

Eligibility Criteria During Transitional Medicaid Coverage, A-841.3
185% FPIL Test, A-844.3
Good Cause Determinations, A-844.4
Parents and Caretaker Relatives Enter or Already Live in the Home, A-846.1
Child Enters or Already Lives in the Home, A-846.2
Household Member Leaves the Home, A-846.3

A-844.2 Staff Action on the Seventh and Tenth Month Medicaid Reports

Revision 21-1; Effective January 1, 2021

TP 07

Use the following procedures to process Form H1146-M, Medicaid Report, for the seventh and tenth months. Take action on the household members' other EDGs and cases if the reported information affects those benefits.

If the household returns Form H1146 and Form H1146 indicates …	then …
the household no longer meets the household composition requirements in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage,	deny the EDG and send Form TF0001, Notice of Case Action.
• there are no earnings by the parent or caretaker relative in at least one of the three report months, and there is no good cause for the lack of earnings; or • the average monthly gross earnings of the household members* exceeds the applicable income limit for the household size,	• deny the EDG using the appropriate denial reason; • open a new EDG for the appropriate Medical Program if applicable; and • send Form TF0001 to the household. If the EDG is denied and the household is not eligible for another type of Medical Program, send Form H1010, Texas Works Application for Assistance – Your Texas Benefits, along with Form TF0001. HHSC must act on received information (earnings) that makes the household ineligible for transitional Medicaid even if the information is received outside of the reporting period (i.e., changes); however, eligibility can only be terminated at the end of the seventh or tenth month. **Note**: If the denial is because the parent or caretaker relative did not have earnings for a complete month, inform the household that they can show good cause. They must show good cause within 13 days. (See A-844.4, Good Cause Determinations.)
the household continues to be eligible,	take no action.
a child who is not receiving TP 43, TP 44, TP 45, TP 48, or transitional Medicaid is in the home,	see A-846.2, Child Enters or Already Lives in the Home.
a child left the home,	see A-846.3, Household Member Leaves the Home.
a returning absent parent or stepparent,	see A-846.1, Parents and Caretaker Relatives Enter or Already Live in the Home.
a household member certified for TP 07 reports a pregnancy,	explore TP40 eligibility for the pregnant household member.

* See A-844.3, 185% FPIL Test, for budgeting policies.

Note: A denial notice (Form TF0001) will be sent to the household at the end of their 12 months of transitional Medicaid.

Related Policy

Eligibility Criteria During Transitional Medicaid Coverage, A-841.3
Good Cause Determinations, A-844.4
Parents and Caretaker Relatives Enter or Already Live in the Home, A-846.1
Child Enters or Already Lives in the Home, A-846.2
Household Member Leaves the Home, A-846.3

A-844.3 185% FPIL Test

Revision 15-4; Effective October 1, 2015

TP 07

Advisors use the following policies and procedures to determine whether the household's earnings are at or below the 185 percent FPIL when processing Medicaid reports.

Advisors must include all members of the individual's MAGI household composition when determining the MAGI income.

Exceptions:

- Advisors must not count the earnings of a child who is exempt according to A-1341, Income Limits and Eligibility Tests.
- See A-240, Medical Programs, and A-1341 for exceptions to household composition and countable income.
- When a person is disqualified because of failure to cooperate with child/medical support or TPR requirements, or is found guilty of a Medicaid intentional program violation, the person is not included in the household size.

If the person who fails to cooperate is …	then …
a certified legal parent,	count the person's earnings.
an "other relative" caretaker who is the parent or stepparent of a child on the case,	count the person's earnings.
an "other relative" caretaker who is not a parent or stepparent to a child on the case,	do not count the person's earnings.

A-844.4 Good Cause Determinations

Revision 15-4; Effective October 1, 2015

TP 07

Good cause for the caretaker relative not having earnings in one or more of the report months includes:

- involuntary loss of employment,
- illness,
- actively looking for work but unable to find a job, and
- other reasons beyond the household's control.

A-845 Reinstatement of Denied Transitional Coverage

Revision 15-4; Effective October 1, 2015

TP 07

Certain households whose transitional Medicaid EDGs are denied before the end of their original eligibility period may have transitional Medicaid coverage reinstated. Advisors must reinstate eligible household members for the remainder of their original transitional Medicaid period if:

- the original transitional Medicaid end date has not expired;
- the TP 07 was denied — for example, members:
  - were recertified for TP 08; or
  - moved out of Texas;
- the household does not want to apply for TP 08 or is not eligible for TP 08 (at application, review, or change); and
- there is a dependent child in the household certified for Medicaid.

Note: Individuals requesting reinstatement of TP 07 transitional Medicaid must have remained continuously eligible for transitional Medicaid during the months the TP 07 EDG was denied. Exception: A household that moved out of Texas must meet all of the eligibility criteria except residence.

A-845.1 Advisor Action on Reinstatements

Revision 15-4; Effective October 1, 2015

TP 07

Advisors must count the months of absence from transitional Medicaid as if the family had actually received transitional Medicaid.

Advisors use the following table to determine the MED:

If the member ...	then enter the day ...
remained in Texas during the transitional Medicaid denial period and did not receive other Medicaid coverage,	following the denial date.
moved out of the state,	the member returned to Texas and was no longer eligible for Medicaid in another state (see A-822, Medicaid Coverage for New State Residents).
was certified for TP 08 or another Medical Program,	following the denial date on the other TP 08 or other Medicaid EDG.

To reinstate denied transitional Medicaid, advisors must:

- Determine which mode to use. If the case status is denied and there is:
  - no active EDG, use Reopen mode.
  - an active EDG, use Complete Action mode.
- On the Program Summary page, select Reactivation from the Program Action drop-down menu.
- On the Program Details page, enter the Reactivation Date and select the appropriate Reactivation Reason.
- From the Program – Individuals Summary display, select the person(s) requesting aid.
- Change Aid Requested to **Yes. Note:** The Date Requested is defaulted to the previous date for individuals who were on the EDG when it was terminated.
- Continue through Data Collection.
- In Disposition, choose Administrative TMA Reinstatement as the reason for eligibility.

Notes:

- Advisors must not open a new application. If a new application was created, it is denied as filed in error.
- When processing the reinstatement, any members who are no longer in the household are removed.
- Advisors send Form TF0001, Notice of Case Action, to notify the household of their continued eligibility.

Advisors must obtain information on household composition and earnings for the months the household did not receive TP 07 and is required to report on Form H1146, Medicaid Report.

If the household missed the …	then obtain information on months …
fourth month Medicaid report,	one, two, and three.
seventh month Medicaid report,	four, five, and six.
tenth month Medicaid report,	seven, eight and nine.

If the household was …	then …
certified for Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or any of the Medical Programs,	use case information, requesting additional information from the household only if necessary.
not certified,	obtain the necessary information.

Advisors determine whether the individual was continuously eligible for TP 07 Medicaid using:

- A-844.1, Advisor Action on the Fourth Month Medicaid Report, for the fourth-month Medicaid Report;
- A-844.2, Advisor Action on the Seventh and Tenth Month Medicaid Reports, for the seventh- and tenth-month Medicaid Reports; and
- A-844.4, Good Cause Determinations, to determine good cause for no earnings.

A-846 Special Household Composition Policies for Transitional Medicaid

Revision 13-2; Effective April 1, 2013

A-846.1 Parents and Caretaker Relatives Enter or Already Live in the Home

Revision 15-4; Effective October 1, 2015

TP 07

Advisors must follow the procedures below if the household requests TP 07 benefits for a caretaker, returning absent parent, stepparent, or second parent in the home.

Advisors must add the member to the case and open a new TP 07 EDG for the individual, or change an ineligible member to eligible if the person is a caretaker or second parent who:

- was disqualified on the TP 08 or transitional EDG but has complied with the eligibility requirement for which he was disqualified (for example, TPR);
- is a returning absent parent/second parent in the home; or
- is a stepparent caretaker because the legal parent has a disability and is unable to care for the children.

A-846.2 Child Enters or Already Lives in the Home

Revision 15-4; Effective October 1, 2015

TP 07

Advisors follow the procedures in the chart below:

- when the TP 07 household reports that a child who is not receiving TP 07, TP 43, TP 44, TP 45, or TP 48 is in the home;
- when denying a TP 08 EDG and opening a TP 07 EDG; and
- upon review of another Medical Program EDG for a child who lives with a TP 07 recipient.

An other-related child's separate Medical Program EDG continues unless the caretaker needs Transitional Child Care services for the child.

If a child who is not receiving TP 43, TP 44, TP 45, TP 48, or transitional Medicaid …	then …
is a newborn, moves in, or already lives in the home,	obtain the appropriate information/verifications and determine if the child meets all of the following requirements: • citizenship, • SSN, • age, • relationship, and • domicile. Use information/verifications from other case records when the child is currently or has been a TANF/Medical Program or SNAP recipient. Do not consider the following criteria: • deprivation, and • income. **Note**: Obtain information regarding a child's earned income when processing the seventh and tenth month Medicaid reports if the child's earnings are counted, following Medical Programs policy explained in A-1341, Income Limits and Eligibility Tests. If the child is eligible, then send Form TF0001, Notice of Case Action, to the household to inform the household of the child's eligibility. If the child is not eligible or the household does not provide the information/verification, then: • send Form TF0001 to the household; • inform the household that: ◦ their TP 07 EDG will continue; but ◦ the child cannot be added to the case, stating the reason the child cannot be added; and • take no action on the case.

If a child who is added to the case has unpaid medical bills for any of the three months prior to the month the request is received to add the child, advisors must:

- determine and document three months prior eligibility according to Medical Programs policies and procedures in A-830, Medicaid Coverage for the Months Prior to the Month of Application; and
- assign the child an MED beginning the first prior month the child met all TP 07 eligibility requirements.

The child's MED cannot precede the:

- first month the household was eligible for TP 07 (advisors must determine a child's eligibility for another Medical Program if the individual applies for prior coverage that precedes the first month the household is eligible for TP 07); or
- date the child entered the household.

A-846.3 Household Member Leaves the Home

Revision 15-4; Effective October 1, 2015

TP 07

Follow the procedures in the chart below when the transitional Medicaid household reports that a child leaves the household.

If a child leaves the household and the …	then …
• child was part of the transitional certified group, and • household continues to meet the household composition requirements in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage,	• send Form TF0001, Notice of Case Action, to the household informing the household that the child will no longer receive Medicaid, and • deny the child's TP 07 EDG.
household no longer meets the household composition requirements in A-841.3,	• send Form TF0001 to the household, and • deny the TP 07 EDGs that no longer are eligible.

Advisors follow normal procedures to remove a parent or caretaker relative when the household reports the person is no longer in the home.

A-846.4 Minor Parents Certified as Children

Revision 15-4; Effective October 1, 2015

TP 07

See A-240, Medical Programs, for household composition rules.

A-847 Other EDG Actions

Revision 13-2; Effective April 1, 2013

A-847.1 Changes Affecting Transitional Medicaid EDGs

Revision 21-1; Effective January 1, 2021

TP 07

For TP 07 EDGs, only take action for the following changes:

- A household member reports a pregnancy. Explore TP 40 eligibility for the pregnant household member.
- A child is born, moves in, or is already living with the certified group. Add the child to the case and open a TP 07 EDG following procedures in A-846.2, Child Enters or Already Lives in the Home.
- A parent or caretaker relative moves in or otherwise becomes eligible. Add the member to the case and open a TP 07 EDG following procedures in A-846.1, Parents and Caretaker Relatives Enter or Already Live in the Home.
- A member included in a TP 07 EDG leaves the household. Remove the member from the case following procedures in A-846.3, Household Member Leaves the Home.
- A household member is no longer eligible. Remove the member from the case. For example:
  - A child no longer meets the Medical Programs age criteria.
  - A child moves out of state.

Related Policy

Parents and Caretaker Relatives Enter or Already Live in the Home, A-846.1
Child Enters or Already Lives in the Home, A-846.2
Household Member Leaves the Home, A-846.3

A-847.2 Reapplication for TP 08

Revision 15-4; Effective October 1, 2015

TP 07

A household receiving TP 07 may reapply for TP 08 by submitting an application. If the household is eligible, TIERS will:

- deny the TP 07;
- certify the parent/caretaker relative on a TP 08 EDG and the child on the appropriate Children's Medicaid EDG; and
- send Form TF0001, Notice of Case Action, to the household.

Related Policy

Minor Parents Certified as Children, A-846.4

A-850, TP 20 Alimony/Spousal Support Transitional Medicaid Coverage

Body

Revision 16-4; Effective October 1, 2016

A—851 Eligibility Criteria for Medicaid when Receiving Alimony or Spousal Support

Revision 21-2; Effective April 1, 2021

TP 20

People denied TP 08 because of new or increased alimony or spousal support may be eligible for TP 20. TP 20 eligibility determinations are based on a parent or caretaker relative certified for TP 08. Household members are eligible for TP 20 for four months following the last month of TP 08 eligibility if:

- the modified adjusted gross income before receipt of alimony or spousal support was at or below the income limit for TP 08;
- new or increased alimony or spousal support income caused the person's MAGI household income to exceed the income limit for the household's size; and
- at least one TP 08 household member was eligible for and received Medicaid in Texas for three of the six months before the first month of ineligibility.

If the household is eligible, a separate transitional Medicaid EDG will be created for each parent or caretaker relative and each child.

When a change in new or increased alimony or spousal support is reported, verified, and processed timely, the first month a person may receive TP 20 is the month after the adverse action period expires (or should have expired if the change was not reported, verified, or processed timely).

A person may receive less than four months of TP 20 coverage if the change of new or increased alimony or spousal support is not reported or processed timely.

Note: If a divorce or separation agreement that includes alimony was executed or last modified after Dec. 31, 2018, alimony received is not counted in the person's household budget.

Related Policy

Determining the First Month of TP 07 Medicaid, A-842.1
Determining the Three of Six Months Eligibility Requirement, A-842.2
Alimony (Spousal Support) Received, A—1326.17
Changes Decreasing Benefits, B-643

A—851.1 Multiple Changes That Cause TP 08 Ineligibility

Revision 15-4; Effective October 1, 2015

TP 08

If two or more changes (when one is new or increased spousal support) cause the income to increase above the Federal Poverty Income Limits (FPIL) for TP 08 for the same month, and the household has not been notified that members are eligible for TP 20, advisors follow the steps below:

Step	Action	
1	If all other case factors remain the same, is the household income increased to above FPIL for TP08 because of new or increased alimony/spousal support?	• Yes. The household is eligible for TP 20 if members meet the other eligibility requirements. • No. Go to Step 2.
2	Is the income increased to above FPIL for TP 08 as a result of a change other than new or increased alimony/spousal support?	• Yes. The household is not eligible for TP 20. Go to Step 3. • No. Go to Step 4.
3	Does the household meet the income limits for the Medical Program EDGs for which they are certified?	• Yes. Continue current Medical Program coverage. • • No. Deny the Medical Program EDG(s) for which the family member is no longer income eligible.
4	Is the income increased to above the FPIL for TP08 when all changes are considered?	Yes. The household is eligible for TP 20 if the members meet the other eligibility requirements.

Changes reported in a timely manner do not stop the denial of the TP 08 EDG and creation of the TP 20 after the household is notified of transitional Medicaid eligibility, even when both changes affect the same month.

Exceptions: The EDG is denied if the household

- moves out of Texas;
- no longer meets the household composition requirement as specified in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage; or
- reports a change that makes the household ineligible before the first month of TP 20 eligibility.

Related Policy

Multiple Changes that Cause TP 08 Ineligibility, A-841.1

A—852 Eligibility Criteria During Transitional Medicaid Coverage

Revision 16-4; Effective October 1, 2016

TP 20

Certified members remain eligible for Medicaid if the household continues to:

- live in Texas; and
- receive alimony/spousal support.

The legal parent who is certified for TP 20 when the advisor receives notice that the legal parent failed to cooperate with child/medical support or TPR requirements or has been found guilty of a Medicaid intentional program violation is denied.

A—853 Automated Process

Revision 16-4; Effective October 1, 2016

TP 08

If the Office of the Attorney General (OAG) receives a new or increased alimony/spousal support collection that is greater than the TP 08 income limits, TIERS determines whether the TP 08 EDG should be denied and a TP 20 opened, or whether the TP 08 EDG should be denied. If either is appropriate, TIERS notifies the individual on Form TF0001, Notice of Case Action.

A—854 Denial of TP 20

Revision 16-4; Effective October 1, 2016

TP 20

Recipients terminated from TP 20 must be retested for eligibility for any other Medical Programs, as explained in A-2342.1, Retesting Eligibility.

A—855 Reinstatement of Denied TP 20 Coverage

Revision 16-4; Effective October 1, 2016

TP 20

Certain households whose TP 20 EDGs are denied before the end of their eligibility period has expired may have transitional Medicaid coverage reinstated. Reinstate eligible household members for the remainder of the original TP 20 Medicaid period if:

- their original transitional Medicaid end date has not expired;
- their TP 20 EDG was denied because the members moved out of Texas; and
- they:
  - do not wish to apply for other medical coverage; or
  - are not eligible for other medical coverage.

Follow procedures in A-845, Reinstatement of Denied Transitional Coverage, to reinstate TP 20 coverage.

A—856 Special Household Composition Policies for Transitional Medicaid

Revision 16-4; Effective October 1, 2016

A—856.1 Parents and Caretaker Relatives Enter or Already Live in the Home

Revision 16-4; Effective October 1, 2016

TP 20

Advisors follow the procedures below if the household requests TP 20 benefits for a caretaker, returning absent parent, stepparent, or second parent in the home.

Advisors must add the member to the case and open a new TP 20 EDG for the individual if the person is a caretaker relative or second parent who:

- was disqualified on the TP 08 or transitional EDG but has complied with the eligibility requirement for which the member was disqualified (for example, child/medical support, TPR); or
- is a returning absent parent/second parent in the home.

A—856.2 Child Enters or Already Lives in the Home

Revision 16-4; Effective October 1, 2016

TP 20

Advisors follow the procedures in the chart below:

- when the TP 20 household reports that a child who is not receiving TP 20 or TP 43, TP 44, TP 45, or TP 48 is in the home;
- when denying a TP 08 EDG and creating a TP 20 EDG; or
- upon review of another Medical Program case for a child who lives with a TP 20 recipient.

Advisors must continue an other-related child's separate Medical Program EDG.

If a child who is not receiving TP 43, TP 44, TP 45, TP 48 or TP 20 …	then …
is a newborn, moves in, or already lives in the home,	obtain the appropriate information/verifications and determine if the child meets all of the following requirements: • citizenship, • SSN, • age, • relationship, and • domicile. Use information/verifications from other case records when the child is currently or has been a TANF/Medical Program or SNAP recipient. Do not consider the following criteria: • deprivation, and • income. If the child is eligible, then: • send Form TF0001, Notice of Case Action, informing the household of the child's eligibility for TP 20; and • add the child to the case and open a new TP 20 EDG for the child. If the child is not eligible or the household does not provide the information/verification, then: • send Form TF0001 to the household; • inform the household: ◦ their TP 20 EDG will continue; but ◦ the child cannot be added to the case, stating the reason the child cannot be added; and • take no action on the case.

A—856.3 Minor Parents Certified as Children

Revision 16-4; Effective October 1, 2016

TP 20

See A-240, Medical Programs, for household composition rules.

A—857 Reapplication for TP 08

Revision 16-4; Effective October 1, 2016

TP 20

A household receiving transitional Medicaid may reapply for TP 08. If the household is eligible, the advisor must:

- deny the TP 20 EDG;
- create the applicable Medical Program EDG; and
- send Form TF0001, Notice of Case Action, to the household.

A-860, Third-Party Resources

Body

Revision 15-4; Effective October 1, 2015

Medical Programs

A TPR is a source of payment for medical expenses other than the recipient or Medicaid. TPR include payments from private and public health insurance and from other liable third parties that can be applied toward the recipient's medical expenses. Title XIX (Medicaid) funds are to be used for the payment of medical services only after all available third-party resources have been used, except for medical services from the following:

- Texas Commission for the Blind;
- Texas Kidney Health Care Program;
- Muscular Dystrophy Association;
- Children with Special Health Care Needs;
- Texas Band of Kickapoo Equity Health Program;
- Maternal and Child Health (Title V);
- State Legislative Impact Assistance Grant (SLIAG);
- Crime Victims Compensation Program; and
- adoption agencies or adoptive parents with medical obligations to the recipient.

Income maintenance insurance policies not related to actual medical expenses are not third-party resources unless the policy is assignable to a hospital or other medical provider.

When an applicant has health insurance, the advisor must instruct the individual to tell medical providers about the health insurance. The provider then bills the insurance company rather than or before billing Medicaid.

Individuals must cooperate:

- in identifying and pursuing any third party who may be liable for medical support payments, including absent parents who pay cash medical support;
- in reimbursing HHSC for medical expenses paid by Medicaid from:
  - court settlements, and
  - liability, casualty, or health insurance payments, and
- with HHSC and its Health Insurance Premium Payment (HIPP) contractor by:
  - providing information about available health insurance coverage;
  - enrolling in their employer's health insurance program; and
  - providing proof of their premium payments.

Individuals who refuse to cooperate without good cause are denied.

The denied legal parent is included in the household composition.

A—861 Third-Party Resources (TPR) and Accidents

Revision 15-4; Effective October 1, 2015

Medical Programs

The advisor must instruct individuals to report any accident-related injuries requiring medical care or accident-related unsettled legal claims within 60 days.

A—861.1 Reporting the Accident to the Third-Party Resources (TPR) Unit

Revision 15-4; Effective October 1, 2015

Medical Programs

If a recipient reports an injury requiring medical treatment for which liability/casualty insurance (the individual's own or someone else's) may provide payment, the advisor must determine the details of the accident and any legal action involved and forward the information by memorandum to:

HHSC/OIG/TPR Unit
MC 1354
P.O. Box 85200
Austin,Texas78708-5200

Advisors must include in the report:

- individual-identifying information;
- the date and nature of the accident and resulting injuries;
- information regarding the liable or potentially liable third party, including the liability insurance policy number and the name and address of the insurance adjuster, if available;
- dates, types, and sources of medical services related to the injury; and
- the status or plans for any legal action, including the name and address of any attorney involved, if available.

A—861.2 Responding to Third-Party Resources (TPR) Unit Noncooperation Notices

Revision 15-4; Effective October 1, 2015

Medical Programs

When the TPR Unit becomes aware of a possible accident through information included on a Medicaid claim form, the TPR Unit contacts the individual to obtain information about the accident.

A—861.3 Third-Party Resources (TPR) Reimbursements

Revision 15-4; Effective October 1, 2015

A—861.3.1 Client-Initiated Reimbursements

Revision 15-4; Effective October 1, 2015

Medical Programs

When a recipient reimburses HHSC for medical expenses from a court settlement or from a liability, casualty, or health insurance payment, the reimbursement should be by personal check, cashier's check, or money order payable to the Texas Department of Health and Human Services.

Advisor action:

1. Give the individual Form H4100, Money Receipt.
2. Send the reimbursement and a copy of Form H4100 to ARTS at P.O. Box 149044, Austin, Texas 78714.
3. Enter the type(s) and date(s) of the medical service(s) in the "For" section of the form.
4. If unsure what medical services were involved, complete a memorandum giving as much information as is known concerning the reimbursement.
5. Attach a copy of any information identifying the nature of the payment, such as a statement from the insurance company, to Form H4100.

The actual claim paid by Medicaid is verified in state office, and the individual is reimbursed if the payment made is in excess of the Medicaid payment. The advisor is notified of the reimbursement. Advisors must consider the reimbursement as possible TANF and/or TP 08 income.

Related Policy

Lump-Sum Payments, A-1331
Reimbursements, A-1332

A—861.3.2 Reporting Non-Reimbursement to the Third-Party Resources (TPR) Unit

Revision 15-4; Effective October 1, 2015

Medical Programs

When an advisor becomes aware that a recipient received a reimbursement for medical expenses paid by Medicaid and failed to reimburse HHSC, the advisor reports the non-reimbursement to the TPR Unit. The advisor must include any available information about the accident and

the payment in the report.

The TPR Unit investigates the claim and reports back. The advisor uses the guidelines in A-861.4, Responding to Third-Party Resources (TPR) Unit Recovery Requests, upon receipt of a memo from the TPR Unit confirming the non-reimbursement.

A—861.4 Responding to Third-Party Resources (TPR) Unit Recovery Requests

Revision 15-4; Effective October 1, 2015

Medical Programs

Advisors use the following chart in responding to TPR Unit recovery requests.

When the TPR Unit becomes aware that an individual received a private insurance payment and has not made any payments to the Medicaid provider, the TPR Unit sends a memo to the regional director. The memo includes the amount of:

- Medicaid paid; and
- the private insurance payment, if known.

The advisor must use the following procedures after receiving the memo:

Step	Action
1	Send Form H1020, Request for Information or Action, to the caretaker, requesting that the individual: • provide verification of the amount of the private insurance payment, and • contact the advisor about reimbursing HHSC. If the individual does not respond, then go to Step 2. If the individual does respond, then go to Step 3.
2	Send Form TF0001, Notice of Case Action, to initiate action to disqualify the legal parent from the certified and/or budget group. Process a referral for intentional program violation if the Medicaid payment was $100 or more. To report waste, abuse or fraud to the OIG/TPR Unit, use the online reporting form https://oig.hhsc.state.tx.us/wafrep/ or call toll-free 1-800-436-6184.
3	Collect the lesser of the: • Medicaid payment, or • private insurance payment. **Note**: If the private insurance payment is greater than the Medicaid payment, count the difference as lump-sum payments for TANF, SNAP and Medical Programs. Refer to A-1200, Resources, and A-1300, Income, for policy on how to count the payments. If the individual does not make a full payment, then go back to Step 2. If the individual makes full payment, then go to Step 4.
4	When the individual makes a payment: • ensure the payment is made by personal check, cashier's check or money order payable to the Texas Department of Health and Human Services; • give the individual Form H4100, Money Receipt. Annotate the form with "TPR/TMHP Insurance Recovery"; and • send a copy of Form H4100 with the payment to Fiscal Division, State Office, E-411.

A—861.5 Remitting Cash Medical Support Payments to the Third-Party Resources (TPR) Unit

Revision 15-4; Effective October 1, 2015

Medical Programs

After certification, Medicaid recipients must remit to the TPR Unit any cash medical support payments received for a certified child. The advisor gives the individual sufficient copies of Form H1710, Payment Identification, and TPR self-addressed envelopes, if payments are being made or might be made. The advisor instructs the individual upon receipt of a cash medical support payment from an absent parent after certification of the requirement to:

- write on the check or money order "Deposit Only - State Treasury" and to **not endorse the check or money order**;
- include Form H1710 with the check or money order; and
- send it to the HHSC/OIG/TPR Unit, MC 1354, P.O. Box 85200, Austin, TX 78708-5200.

If the individual turns in cash medical support payments to the local office, the advisor must:

- forward the payment(s) to the HHSC/OIG/TPR Unit; and
- give the individual a copy of Form H4100, Money Receipt.

Upon becoming aware that an individual did not remit a cash medical support payment, advisors must follow policy in B-700, Claims, and process a claim for the month(s) of unreported income, if required.

Related Policy

TANF, A-1124
Medical Support Payments, A-1326.2.3

A—862 Third-Party Resources (TPR) Reporting System

Revision 15-4; Effective October 1, 2015

Medical Programs

The application asks applicants and individuals whether any household members have health insurance. Form H1028, Employment Verification, asks employers to verify if health insurance is available, and whether the employee is enrolled. When an individual reports a new job or a change in employers, the advisor determines whether there is any new or potential private health insurance coverage for certified household members during the eligibility interview or application processing.

If information from the individual, the employer or other source indicates ...	then report ...
Medicaid-eligible household members have private health insurance coverage,	information about the private health insurance in the Third Party Resources logical unit of work of the case the individual is a member of in TIERS.
health insurance coverage is available for Medicaid-eligible household members but the members are not enrolled in the health insurance plan,	information about the available health insurance in the Third Party Resources logical unit of work of the case the individual is a member of in TIERS. The TPR Unit will use the information to initiate an inquiry about HIPP Program eligibility.

To contact the TPR Unit about TPR questions or problems:

- advisors may call 1-800-846-7307.
- clients may call the Client Medicaid Hotline at 1-800-252-8263.

A—863 Health Insurance Premium Payment (HIPP) Program

Revision 17-1; Effective January 1, 2017

Medical Programs

The Health Insurance Premium Payment (HIPP) program is a Medicaid benefit that helps families pay for employer-sponsored health insurance.

To qualify for HIPP, an employee must either be Medicaid eligible or have a family member that is Medicaid eligible. The HIPP program may pay for individuals and their family members who receive, or have access to, employer-sponsored health insurance benefits when it is determined that the cost of insurance premiums is less than the cost of projected Medicaid expenditures.

Note: An employee and their Medicaid-eligible family member must be enrolled in the employer-sponsored health insurance in order to receive HIPP reimbursements.

Medicaid-eligible HIPP enrollees do not have to pay out-of-pocket deductibles, co-payments, or co-insurance for health care services that Medicaid covers when seeing a provider that accepts Medicaid. Instead, Medicaid reimburses providers for these expenses.

HIPP enrollees who are not Medicaid eligible must pay deductibles, co-payments, and co-insurance required under the employer's group health insurance policy.

Report individuals who are potentially eligible for HIPP on Form H1039, Medical Insurance Input. Send Form H1039 to HHSC's Third Party Resource (TPR) Unit, Mail Code 1354.

HHSC's TPR Unit refers Form H1039 to the current state Medicaid contractor, Texas Medicaid and Healthcare Partnership (TMHP). If TMHP determines it is cost-effective for Medicaid to pay the recipient's employer-sponsored health insurance premiums, then TMHP sends:

- a letter to the recipient and requests verification of the employer-sponsored insurance plan and premium payments; and
- a premium reimbursement to the recipient upon receipt of complete documentation and proof of the premium payment.

Note: Do not consider an incurred medical deduction for the reimbursed premium for individuals participating in HIPP.

TMHP will terminate HIPP enrollment if the individual is no longer enrolled in health insurance coverage or fails to provide TMHP with the information needed to determine cost effectiveness or proof of premium payments.

For more information about the HIPP program, see HHSC's website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program, or contact the Medicaid HIPP program at MCD_HIPP_Program@hhsc.state.tx.us.

Individuals may call 800-440-0493 for more information.

Related Policy

Reimbursements, A-1332

A-870, Verification Requirements

Body

Revision 20-2; Effective April 1, 2020

Medical Programs

Verification is required for the following:

- Spousal support to establish eligibility for TP 20
- Unpaid medical bills for three months prior coverage. **Exception**: Refer to A-831.2, Eligibility for Three Months Prior Coverage, for TP 40 prior coverage
- Income for each of the three months prior to coverage. **Note**: For Children's Medicaid, do not request more income verification for prior Medicaid coverage than what is required for ongoing eligibility. See A-1371, Verification Sources, for Children's Medicaid.
- An application was filed when reopening an application for prior month coverage according to A-831.2.1, Reopening Three Months Prior Applications
- Gross earnings and the date the person received the earnings for TP 07. **Exception**: If verification is not readily available, accept the person's statement unless questionable. If the household provides earnings information sufficient to determine eligibility for TP 07 but does not provide verification of the earnings, deny the TP-08 EDG and create a TP 07 EDG if the person meets the eligibility requirements in A-842, TP 07 Transitional Medicaid.
- When a household requests continuation of Medicaid for children aging out of TP 44, verify the child:

    - is hospitalized on the child's 19th birthday;
    - remains hospitalized (there is not a time limit); and
    - meets all other criteria according to policy in A-825, Medicaid Termination.
- Third-Party Resource (TPR). Report to the TPR Unit any household member who:
    - has private medical insurance; or
    - is not enrolled in group medical coverage that is available to him.

Emergency Medicaid

Verify the emergency medical condition by using Form H3038, Emergency Medical Services Certification, or Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification. These forms are the only acceptable sources that can be used to verify an emergency medical condition. A licensed practitioner must complete and sign Form H3038 or Form H3038-P.

Note: An original or a faxed copy of Form H3038 or Form H3038-P is acceptable to verify the emergency medical condition.

TP 40

See A-144.5, Pregnancy, for policy relating to verification of pregnancy.

Related Policy

Pregnancy, A-144.5
Regular Medicaid Coverage, A-820
Verification Requirements, A-1370
A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20, B-480
Questionable Information, C-920
Providing Verification, C-930

A-880, Documentation Requirements

Body

Revision 21-2; Effective April 1, 2021

Medical Programs

Document:

- Verification of income and unpaid medical bills for the three months prior coverage.
- Medical insurance other than Medicaid.
- Method of income computation.
- Eligibility for transitional Medicaid.
- Reason for assigning less than the maximum transitional Medicaid coverage.
- Denial of TP 20 because spousal support payments stopped.
- Reason for action on a Medicaid EDG.
- Gross earnings and the dates the person received the earnings.
- Cost of health insurance premium for the child(ren) before certifying for CHIP.
- Name and phone number of state hospital employee.

If the household requests continuation of Medicaid for children aging out of TP 44, follow policy in A-825, Medicaid Termination, and document that the child:

- is hospitalized on their 19th birthday;
- remains hospitalized through the end of their eligibility period; and
- meets all other criteria according to A-825 .

If providing prior coverage for more than three months, follow policy in A-831.2.1, Reopening Three Months Prior Applications, and document that:

- there was an application on file to cover any of the prior months; and
- the file date on the application was used to cover these months.

TP 40

Document the pregnancy verification method and the anticipated delivery date.

Related Policy
Medicaid Termination, A-825
Reopening Three Months Prior Applications, A-831.2.1
Third-Party Resources, A-860
Documentation Requirements, A-950
Documentation, C-940

A-900, Domicile

A-910, General Policy

Body

Revision 16-4; Effective October 1, 2016

TANF

A child must live in the home with a relative listed in A-221, Who Is Included, No. 4. A home is the family setting maintained or being established, as evidenced by continuation of responsibility for day-to-day care of the child by the relative with whom the child is living.

Medical Programs except TP 08 and TA 31

Domicile requirements do not apply to these programs. Children can live with a parent or caretaker relative, or not live with a parent or caretaker relative (for example, independent children).

TP 08 and TA 31

For a parent or caretaker relative to be eligible for TP 08 or TA 31, they must be living with the dependent child of whom they have care and control. In general, for a caretaker to be considered as having care and control of a child, the child must live in the home with the relative. A home is the family setting maintained or being established, as evidenced by continuation of responsibility for day-to-day care of the child by the relative with whom the child is living.

The parent or caretaker relative may meet the domicile requirement when the dependent child is not included in their Modified Adjusted Gross Income (MAGI) household composition.

Example: A grandfather is living with his grandchild, but the grandchild is claimed as a tax dependent by a non-custodial parent. The grandfather is applying for health care for himself. In this example, the grandchild is not included in the grandfather's MAGI household composition since the grandfather is not claiming the grandchild as a tax dependent. However, the grandfather meets the domicile requirement if the grandchild lives with the grandfather and meets the care and control requirements explained in A-921, How to Determine Care and Control.

Related Policy
Children Admitted into State Hospitals, A-922
Children Residing in General Residential Operations Facilities, A-923

A-920, Temporary Absence from the Home

Body

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Advisors must not deny assistance because a household member or payee is temporarily out of the home if all of the following conditions are met:

- The person is out of the home due to:
  - temporary separation from other family members, and the family has no regular place of residence;
  - hospitalization or receipt of outpatient services;
  - attending school or training (including schools for the deaf and blind);
  - being on vacation;
  - being in a home for children not considered to be a public institution; or
  - seeking employment away from home.

- The parent or caretaker relative/payee is still responsible for the child's care and control. See A-921, How to Determine Care and Control, to determine whether the caretaker/payee still has care and control.
- The person's absence is not anticipated to be more than the allowable six- or 12-month period.

Advisors must certify or continue eligibility, and review the Eligibility Determination Group (EDG) every three months. Advisors remove the absent household member from the EDG after:

- six months (beginning with the first full month of absence from the home); or
- 12 months for situations when a family member is out of the home because the member is:
  - hospitalized or receiving outpatient services;
  - attending school or training; or
  - in a home for children not considered to be an institution.

The allowable six- or 12-month period begins again if the absent person returns to and resides in the home for at least 30 consecutive days. Advisors must not apply the temporary absence time frames when a parent is out of the home solely because of employment. Advisors must include the employed parent in the certified group if the parent meets all other eligibility criteria. See A-1040, Deprivation Based on Absence from the Home.

If a member of the certified group enters a nursing home, advisors leave the member's needs in the household composition if the member will be there temporarily or until the member is certified for Supplemental Security Income (SSI). Advisors refer the recipient to the Social Security office for an SSI eligibility determination.

TANF

If the advisor removes the caretaker from the EDG, the EDG must be denied, and the advisor must ask another relative in the home that qualifies as caretaker to apply for the child(ren).

Medical Programs

If the advisor denies the parent or caretaker relative's EDG, this does not impact the other associated Medical Program EDGs, and the other individuals cannot be required to reapply for Medical Programs.

A—921 How to Determine Care and Control

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

The parent or caretaker relative/payee cannot be considered responsible for the absent child's care and control when the child:

- is placed out of the caretaker/payee's home by the court, and the caretaker/payee has no authority to remove the child; or
- has a court-appointed guardian other than the caretaker/payee.

These children are independent children. The advisor must determine their eligibility for one of the Medical Programs.

Other considerations for care and control include:

- Who has the financial responsibility for the child's medical and dental costs?
- Who makes the decisions about health care, medical care, schooling and other personal care decisions?
- To what extent is the caretaker/payee involved with the child? How often does the caretaker/payee visit the child? What is the caretaker/payee's involvement with decisions for the care, well-being, schooling, etc.?
- To what extent does the caretaker/payee actively participate in the guidance and development of the child?
- What is the caretaker/payee's financial involvement for the child? That is, does the caretaker/payee pay a regular fee for the child's enrollment and participation in the home's programs?
- What restrictions or limitations have been placed on the caretaker/payee's rights?

Based on the responses to these questions, the advisor must make a prudent person decision about the caretaker/payee still being responsible for the child's care and control.

Related Policy

Prudent Person Principle, A-137

A—922 Children Admitted into State Hospitals

Revision 15-4; Effective October 1, 2015

Medical Programs except TP 08 and TA 31

Advisors consider a child admitted into a state hospital as an independent child if the caretaker no longer has care and control and the child was admitted:

- via a court order, or
- voluntarily.

The child is not considered an independent child if the child was admitted voluntarily and the caretaker/payee continues to have care and control.

A—923 Children Residing in General Residential Operations Facilities

Revision 24-1; Effective Jan. 1, 2024

Medical Programs except TP 08 and TA 31

A child admitted into a general residential operations facility is an independent child because these facilities have care and control over the children. Facilities that are members of the Texas Coalition of Homes for Children are considered general residential operations facilities.

Once a child is placed in a general residential operations facility, the facility provides a live-in house parent model of care. The house parent(s) assumes responsibility for the child and acts in lieu of the parent(s) to meet the child's ongoing needs.

A facility may apply for medical assistance on behalf of a child under its care. The facility has limited power of attorney and is considered an alternate payee for a child's Medicaid EDG.

The facility submits an application listing the child as a case name and a representative from the facility as an authorized representative (AR). If the representative is no longer affiliated with the facility, the facility must name a new representative to serve as the child's AR.

If an independent child is in a facility that is not a member of the Texas Coalition of Homes for Children:

- submit Form H0005, Policy Clarification Request
- include a copy of the placement contract; and
- the power of attorney from that facility.

When a child moves out of a facility, the facility's AR must report the change of address and end the AR designation.

Related Policy

Authorized Representatives (AR), A-170
Children's Living Arrangements, A-241.3.1
Verification Requirements, A-940
Verification Sources, A-941
Reporting Requirements, B-620

A—924 Disqualification for Failure to Report Temporary Absence

Revision 15-4; Effective October 1, 2015

TANF

If a caretaker relative (a legal parent or other caretaker relative) fails to timely report the temporary absence of a certified child, the caretaker relative is disqualified until the earlier of the following occurs:

- the child returns to the home,
- the child is removed from the certified group, or
- the EDG is denied.

Related Policy

TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction, A-1362.2
General Policy, A-1210

A-930, Requirement for Unmarried Minor Parents to Live with an Adult or in an Adult-Supervised Setting

Body

Revision 25-4; Effective Oct. 1, 2025

TANF

To receive Temporary Assistance for Needy Families (TANF) benefits, unmarried minor parents must live:

- with a parent, legal guardian or adult relative; or
- in a local second chance home, maternity home or other residential facility that provides an adult-supervised living arrangement, if available in the local community, if the unmarried minor parent:
  - has no parent, legal guardian, or adult relative:
    - who is living;
    - whose whereabouts are known; and
    - who is willing and appropriate; or
  - cannot live with such a person because of prior or potential abuse or neglect.

Note: The unmarried minor parent does not have to be included in a TANF EDG with the minor parent's parent unless required by policy.

Staff must notify the minor parent of available local facilities.

An unmarried minor parent and child are not required to live in a second chance home, maternity home or other adult-supervised living arrangement if it is not in their best interest. Staff, using the prudent person principle, determines if the unmarried minor parent's current living arrangement is in their best interest.

In their best interest means either:

- there is no parent, legal guardian or adult relative that the minor parent and child can live; or
- there is no adult-supervised facility in the community; or
- their current living arrangement provides as much or more safety and emotional or financial security than living in a local adult-supervised facility.

Examples:

- An unmarried minor parent is employed, their child has safe child care, and the move would result in the loss of employment.
- An unmarried minor parent lives alone or with a family friend, has no living adult relative, and no alternative adult-supervised facility is available in the community.

Related Policy

Who is Included, A-221

A-931 Failure to Comply

Revision 25-4; Effective Oct. 1, 2025

TANF

Staff must disqualify an unmarried minor parent who fails to comply with the requirement to live with a parent, legal guardian, adult relative, or in an adult-supervised living arrangement.

Related Policy

Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits, A-1362.1

A-940, Verification Requirements

Body

Revision 25-4; Effective Oct. 1, 2025

TANF, TP 08 and TA 31

Verify that a person meets the 30-day domicile requirement before allowing more temporary absence periods.

Related Policy

Temporary Absence from the Home, A-920

TANF

Verify domicile:

- at application and redetermination for all certified children; and
- when a change occurs:
  - for newly added children; or
  - if questionable, for all certified children.

For an unmarried minor parent:

- verify domicile at application and redetermination;
- request a verbal or written statement from the parent, legal guardian, adult relative or an employee of the adult-supervised setting; or
- contact school officials or use a current school record showing the same address as the parent, legal guardian, adult relative or approved adult-supervised setting.

TP 08 and TA 31

Verify domicile of a dependent child:

- at application and redetermination; and
- when a change impacts the living situation or care and control of the dependent child.

Medical Programs

Verify verbally with a state hospital employee if a child entered a state hospital via a court order or if the child was admitted voluntarily. If the child was admitted voluntarily, determine if the caretaker or payee still has care and control.

Verify verbally with a facility employee a child's placement into a general residential operations facility.

Related Policy

Children's Living Arrangements, A-241.3.1
Children Admitted into State Hospitals, A-922
Children Residing in General Residential Operations Facilities, A-923

A-941 Verification Sources

Revision 25-4; Effective Oct. 1, 2025

TANF, TP 08 and TA 31

- For a preschool-age child, staff must:
  - observe the interaction between the child and caretaker or payee in either the home or the office;
  - request a verbal or written statement from a non-relative landlord; or
  - request a verbal or written statement from a non-relative neighbor.
- For a school-age child, staff must:
  - request the name of the school for each school-age child. If the person does not know where the child attends school and cannot provide a reasonable explanation, consider domicile questionable. When domicile is questionable, contact the school to verify domicile.
- If domicile is not questionable, use any of the following sources to verify domicile:
  - contact school officials or use a current school record showing the same address as the caretaker;
  - a verbal or written statement from a non-relative landlord;
  - a verbal or written statement from a non-relative neighbor; or
  - follow the same observation procedures for a preschool-age child if it does not interfere with school attendance.
- For people reported as released from juvenile placement by Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department, use the Juvenile Medicaid Tracker.

If a child is home schooled, request domicile verification from another collateral source. Send Form H1020, Request for Information or Action, to request additional verification from the household when domicile is questionable. To request written domicile verification from a non-relative or a non-relative landlord, send:

- Form H1155, Request for Domicile Verification; or
- Form H1857, Landlord Verification.

Medical Programs except TP 08 and TA 31

Staff may accept self-declaration as verification of domicile.

For a child placed into a general residential operations facility, request verification of:

- limited power of attorney for health care and educational services; and
- placement contract.

Related Policy

Children's Living Arrangements, A-241.3.1
Children Residing in General Residential Operations Facilities, A-923
Verification Requirements, A-1640
Questionable Information, C-920
Providing Verification, C-930

A-950, Documentation Requirements

Body

Revision 26-2; Effective April 1, 2026

TANF and Medical Programs

Document:

- information from the verification source to verify the children live in the home including name and address, or phone number for collateral contacts;
- the reason for any temporary absence;
- information from the verification source to verify the household member or payee returned to and lived in the home for at least 30 days when allowing another temporary absence period;
- the living arrangement for unmarried minor parents;
- if the caretaker or relative continues to provide care and control when a child is admitted voluntarily into a state hospital;
- if a child was admitted into a state hospital voluntarily or by a court order; and
- if a child was admitted into a general residential operations facility.

TANF

Document the school's name, obtained from the caretaker or payee either during the interview or as missing information, for each school-age child.

TANF

Document how the minor parent meets or does not meet the requirement for unmarried minor parents to live with an adult or in an adult-supervised setting.

Related Policy

Requirement for Unmarried Minor Parents to Live with an Adult or in an Adult-Supervised Setting, A-930
Documentation, C-940
The Texas Works Documentation Guide (PDF)

A-1000, Deprivation

A-1010, General Policy

Body

Revision 15-4; Effective October 1, 2015

TANF

Deprivation is the loss of financial support from a legal parent for one of the following reasons:

- absence of parent(s) from the home;
- death of parent(s);
- physical or mental incapacity of parent who is living in the home; or
- unemployment or underemployment of one or both parents in a two-parent household.

A-1020, Establishing Deprivation for Children of Unwed Parents

Body

Revision 04-7; Effective October 1, 2004

A—1021 Unwed Parents Living Together

Revision 15-4; Effective October 1, 2015

TANF

When a child lives with both biological parents and the father:

- is not married to the child's mother;
- is not the legal father as determined through court adjudication; and
- acknowledges paternity,

staff should follow the procedures below to establish deprivation:

If the child's mother …	then …
is or was married (other than by common-law) to another man presumed to be the child's legal father,	**the child is** deprived based on absence and the biological father should not be certified. Both fathers must be referred to the Attorney General (see A-1100, Child Support).
was never married to a man presumed to be the child's legal father,	**the child is** deprived, but not based on absence.
was married by common-law to another man,	**the child is** deprived, but not based on absence.

A—1022 Paternity Conflicts — Unwed Parents

Revision 15-4; Effective October 1, 2015

TANF

If an application is filed for a child living with the mother and a man who may be the child's father and the couple disagrees about paternity, the mother must provide written proof of her statement.

If the mother proves the man is …	then deprivation is …
the child's father,	not based on absence, but rather on the relationship to the biological father living in the home.
not the child's father,	based on absence.

If the mother is unable to provide written proof, staff must accept the man's statement and determine deprivation accordingly. If there are other paternity conflicts, assistance should be requested from the regional attorney.

A-1030, Deprivation Based on Death of a Parent

Body

Revision 15-4; Effective October 1, 2015

TANF

Deprivation exists when a child's legal parent(s) is deceased. Staff must explore possible survivor's benefits for the child and/or remaining parent.

A-1040, Deprivation Based on Absence from the Home

Body

Revision 03-7; Effective October 1, 2003

A-1041 How to Determine Deprivation Based on Absence

Revision 15-4; Effective October 1, 2015

TANF

Deprivation based on absence exists when:

- a child's legal parents do not live together because of:
  - divorce,
  - legal separation,
  - desertion,
  - incarceration, or
  - deportation;
- the child's biological father lives in the home with the mother and child but a legal parent-child relationship exists between the child and another man;
- a parent resides outside the U.S. and there is a legal impediment that prevents the parent from living in this country; or
- a parent convicted of an offense and sentenced by a court to perform unpaid community service during work hours lives at home while serving the sentence.

If absence is anticipated to last for:

- 30 days or less, the absence is considered temporary and the child is not deprived.
- more than 30 days, the absence is considered continuing.

Note: If the absence is currently less than 30 days but is anticipated to last longer than 30 days, the Eligibility Determination Group (EDG) should not be pended for deprivation.

A parent should be included in the certified group if the parent is temporarily absent for a reason listed in A-920, Temporary Absence from the Home.

Deprivation based on absence does not exist when a parent is absent solely because of:

- employment; or
- active duty in the uniformed services of the United States, even if the parent is incarcerated or absent without leave (AWOL).

Exception: Deprivation may exist if there is a break in the family relationship unrelated to active duty in the service, and information indicates the family members are not functioning as a family unit. Information can be a statement from the caretaker that she and the second parent consider themselves to be separated so that the parents and children are not functioning as one family unit.

A-1041.1 Joint Custody

Revision 15-4; Effective October 1, 2015

TANF

A child living with parents who have court-ordered joint custody may be deprived based on absence. In joint custody cases, either parent may apply for Temporary Assistance for Needy Families (TANF) for the child. When the child alternately lives with either parent each month, either parent may apply. See A-910, General Policy.

A-1042 Contact with the Absent Parent

Revision 15-4; Effective October 1, 2015

TANF

Contact the …	when the address or phone number is known and …	Determine …
legal absent parent,	• there is reason to believe the absent parent is making cash contributions other than child support; or • conflicting information is provided regarding the parent's absence.	• if the absent parent is making contributions other than child support; • the reason for the absence; • how long the absent parent has been absent; and • if the absent parent has plans to return and the anticipated return date.
alleged parent with no legal parent-child relationship,	• there is reason to believe the absent parent is making contributions other than child support to the household; or • the absent parent lives in the home and is a potential legal father through common-law marital status.	• if the absent parent is making contributions other than child support; or • if a common-law marriage exists.

Advisors must notify the applicant/individual before contacting the absent parent. Advisors should not contact the absent parent if the individual has a pending or valid claim of good cause. See A-1130, Explanation of Good Cause.

A-1043 Absent Parent Returns to the Home (Extension of the TANF Grant or Addition of the Returning Parent)

Revision 15-4; Effective October 1, 2015

TANF

When an absent parent returns to the home, the absent parent should be added to the case following policy in B-641, Additions to the Household, and eligibility and benefits should be determined.

- If eligible, advisors must document the new reason for deprivation and notify the Office of the Attorney General (OAG).
- If ineligible, advisors must deny TANF. If the absent parent's earnings cause the case to be denied, advisors must transfer the case to TP 07 and include the absent parent.

Related Policy Earnings of a New TANF Spouse, A-1249.2

A-1050, Deprivation Based on Incapacity

Body

Revision 15-4; Effective October 1, 2015

TANF

A parent is incapacitated if a medically determined mental or physical impairment results in a substantial reduction in the ability to support or care for the child. This impairment kept or will keep the parent from performing the parent's usual work for at least 30 days.

The individual's usual work is the individual's main occupation for the last 15 years. In the case of a homemaker, the activities related to caring for a child are considered usual work.

A—1051 Determining Incapacity

Revision 15-4; Effective October 1, 2015

TANF

Advisors must determine whether the household meets all other eligibility criteria. If the household meets all other eligibility criteria, a disability determination request should be processed as follows:

1. Advisors must determine whether the household is receiving Supplemental Security Income (SSI) or Retirement, Survivors and Disability Insurance (RSDI) based on disability. If the individual receives either of these benefits, deprivation is established. **Note:** Eligibility for SSI or RSDI based on age does not establish deprivation.
2. If the applicant has a disability that is:

- obvious, advisors must certify the household for TANF and require a completed Form H1836-A, Medical Release/Physician's Statement, at the next redetermination.
- not obvious, the advisor must complete the disability determination. A disability determination consists of the advisor completing and sending Form H1836-A to the physician who treated the individual within the past 60 days for the incapacity being claimed. **Note:** The physician is not paid for completing this verification.

If Form H1836-A is returned indicating that the individual has …	then the household should be certified for …
a temporary disability,	TANF or TANF-State Program (SP), and the individual must be informed that the disability will be reviewed at each periodic redetermination.
a permanent disability,	TANF or TANF-SP.
no disability,	TANF or TANF-SP, and the requirements for participation in the Choices program must be explained.

A—1052 Processing Medical Reviews

Revision 15-4; Effective October 1, 2015

TANF

Medical reviews must be processed at each periodic review following the steps in A-1051, Determining Incapacity.

If the disability was …	then …
determined at initial certification without Form H1836-A, Medical Release/Physician's Statement, or was temporary and has ended (based on Form H1836-A) and the individual still claims to have a disability,	the advisors must require the individual to provide Form H1836-A before recertifying the case. If the individual does not provide the statement and the disability is not established, the advisor must then certify the household for TANF, if otherwise eligible.
permanent (based on Form H1836-A) and has not ended,	the advisor must continue to base deprivation on incapacity and not require another Form H1836-A unless the individual is working and/or the condition has improved.

A-1060, Deprivation Based on Unemployment

Body

Revision 02-8; Effective October 1, 2002

A—1061 How to Determine Deprivation Based on Unemployment

Revision 15-4; Effective October 1, 2015

TANF

Deprivation based on unemployment may exist when a legal parent is:

- unemployed, or
- underemployed.

A-1070, TANF-State Program

Body

Revision 15-4; Effective October 1, 2015

TANF-SP

Eligibility for TANF-SP may be determined when:

- a child lives with both of the child's natural or adoptive legal parents/stepparents, even if one or both are disqualified for one of the reasons listed in A-222, Who Is Not Included, No. 4, Disqualified Members, unless that disqualification is due to not meeting citizenship requirements; and
- the household meets all other TANF eligibility requirements.

A—1071 Employment Services Requirements

Revision 02-8; Effective October 1, 2002

A—1071.1 Choices Requirements

Revision 15-4; Effective October 1, 2015

TANF

Choices participation requirements and procedures are explained in A-1800, Employment Services.

A-1080, Disability Verification

Body

Revision 15-4; Effective October 1, 2015

TANF

Verify the disability status using Form H1836-A, Medical Release/Physician's Statement.

A—1081 Verification Sources

Revision 15-4; Effective October 1, 2015

TANF

Death

Sources for verification of death include:

- copy of death certificate;
- Birth Verification System record;
- doctor's statement;
- Social Security claim number or evidence of receipt of widow's or survivor's benefits from the deceased person's Social Security number;
- U.S. Department of Veterans Affairs or military service records;
- Indian census record;
- statement from funeral director;
- records from the hospital or other institution where the person died; and
- insurance company records.

Alternate sources include:

- newspaper death notice listing survivors;
- state or local public assistance records (including burial payment records);
- lodge, club or other organization records;
- police records;
- statement from clergy; and
- "In Memoriam" card.

Sources for verification of continued absence include:

- statement from the absent parent;
- rent receipt/statement from the absent parent's non-relative landlord;
- statement from clergy, landlord, or other knowledgeable non-relative;
- correctional institution records;
- telephone directory;
- absent parent's child(ren)'s school records;
- tax records;
- absent parent's employment records;
- union records;
- court records;
- statement from law enforcement officials;
- insurance records;
- medical records;
- post office address records for the absent parent;
- other agency records;
- absent parent's unemployment compensation records;
- Department of Motor Vehicles record showing the absent parent's address (includes driver license, identification card, and motor vehicle registration);
- city or crisscross directory; and
- Social Security, U.S. Department of Veterans Affairs, or other government agency records.

Sources for proof of deprivation for TANF-SP include:

- Texas Workforce Commission inquiry;
- tax records;
- check stubs;
- employer's statement;
- business records; and
- Form H1028, Employment Verification.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A-1090, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

TANF

Advisors must document the:

- facts about the incapacity and any expected changes;
- processing dates of incapacity applications and reviews;
- facts about good cause claims;
- facts about adverse actions for noncooperation;
- name and last known address of the legal and/or biological father of an unborn child, if the mother receives TANF;
- permanent or temporary disability status; and
- basis for a special review and the special review date.

Related Policy

Documentation, C-940

The Texas Works Documentation Guide

A-1100, Child Support

A-1110, General Policy

Body

Revision 26-2; Effective April 1, 2026

TANF and Medical Programs

The Office of the Attorney General (OAG) Child Support Division is responsible for the child support program. The OAG attempts to establish and enforce child support and medical support for children on Temporary Assistance for Needy Families (TANF) and certain medical programs.

TANF

Caretakers and payees must cooperate to get child support and medical support for a child receiving TANF unless good cause exists.

TP 08

Parents and caretaker relatives are mandatory participants. They must cooperate to get medical support for a child receiving Medicaid unless good cause exists. They may refuse help in getting child support, but not medical support. If the applicant refuses help getting child support, the OAG will not attempt to establish or enforce child support unless the applicant has a previous TANF case with arrears that must be paid back to the state. Staff must explain to applicants, if an interview is conducted, that when the OAG pursues medical support, Texas courts also pursue a child support order. If the applicant chooses medical support only, the OAG will not attempt to enforce the child support orders.

Note: Staff must request information on parents living outside of the home as this information is not requested for Medical Programs on the application. If an interview is not conducted, staff must request this mandatory information using Form H1020, Request for Information or Action, and send the household Form H1712, Explanation of Child, Medical Support, Family Violence and Good Cause and Form H1713, Service Plan for Family Violence Option and Report of Good Cause.

Related Policy

Explanation of Good Cause, A-1130

Medical Programs except TP 08

Medical support requirements do not apply to other medical programs. Applicants may volunteer to receive child or medical support services. There is no penalty for noncooperation.

Note: The OAG may contact and continue to collect benefits for a household receiving only children's medical assistance due to previous receipt of TANF.

Households may contact the OAG with questions or for help getting OAG services by calling 800-252-8014.

A-1111 Office of the Attorney General (OAG) Case Information and Inquiry

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

If the custodial or noncustodial parents or employers have questions regarding child support payments, distribution, or withholdings, they should be referred to the local child support office or to 1-800-252-8014.

Custodial or noncustodial parents should be referred to the local OAG office if they request verification and certification of public assistance received. The OAG staff complete Form 1740, Request for Public Assistance Payment Certification, when the amount of public assistance is in question or when it is needed in court to establish child support. Texas Health and Human Services Commission (HHSC) Fiscal Management Services (E-411) researches and certifies the amounts and date on Form 1745, Report of Total Public Assistance Payments, for the OAG.

A-1120, Child Support Program Requirements and Procedures

Body

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Form H1712, Explanation of Child/Medical Support, Family Violence and Good Cause, is used to explain the:

- child support process;

- benefits of the child support program;
- penalties for noncooperation;
- details about the family violence option;
- details of the good cause claim for not cooperating; and
- individual's responsibility to:
  - provide information to the OAG and HHSC on all possible biological and/or legal parent(s);
  - help the OAG find the absent parent;
  - help the OAG establish paternity, if necessary;
  - go to the OAG office or to court to sign papers or provide necessary information; and
  - remit all child/medical support payments received after TANF is approved.

A-1121 Authorization and Assignment of Child and Medical Support

Revision 15-4; Effective October 1, 2015

TANF and TP 08

The assignment of rights to child and medical support is accomplished when an applicant signs an application that includes a request for TANF or TP 08. Signing the application gives the OAG permission to receive and process any child or medical support payments made payable to the child.

A-1122 Parent Profiles for Child and Medical Support Referrals

Revision 02-6; Effective July 1, 2002

A-1122.1 Parent Profile Questionnaire

Revision 26-2; Effective April 1, 2026

TANF, TP 08, and TA 31

The information requested on Form H0050, Parent Profile Questionnaire, is required for each absent parent. The absent parent information may be obtained verbally. Enter the information to the **Absent Parent** page in the eligibility determination system. If a child has both a legal and a biological absent parent, information on both the legal and biological parent is required unless the person can reasonably explain why it is impossible to provide information or has established good cause. The person must provide the following information about the absent parent:

- the absent parent's first and last name;
- information about the relationship between the child's parents, such as divorced, separated or never married; and
- at least one of the following:
  - the absent parent's Social Security number;
  - the absent parent's current or last known address; or
  - the absent parent's current or previous employer information.

Staff must address each item on Form H0050 and help the person get information about the absent parent(s). The OAG establishes cases based on information collected from the applicant and entered by HHSC staff. Failure to provide complete and accurate information may affect the successful enforcement of child support.

TP 08 and TA 31

An interview is not required. If absent parent information is not provided on the application, staff must request the information using Form H1020, Request for Information or Action.

TP 43, TP 44 and TP 48

If the person volunteers to receive services provided by the OAG, staff must collect absent parent information as noted above and refer the child's Eligibility Determination Group (EDG) to the OAG.

Related Policy

Explanation of Good Cause, A-1130

A-1122.2 Child Support and Medical Support Referrals

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs except TP 40 and TP 36

Advisors must send referrals to the OAG on legal and biological parent(s):

- when deprivation is based on absence;
- when deprivation is based on death;
- if paternity cannot be established using policy in A-1021, Unwed Parents Living Together, for a biological father who is in the home;
- if the family volunteers to receive services provided by the OAG for Children's Medicaid programs; or
- the adult caretaker receives TP 08. See A-1122.1, Parent Profile Questionnaire, for Children's Medicaid programs.

Advisors do not send a referral if:

- a child in the home is not deprived because both parents are in the home or deprivation is based on unemployment or underemployment (TANF-State Program [SP]);
- a claim of good cause has been established;
- deprivation is based on physical or mental incapacity; or
- the legal or biological father of a pregnant woman's unborn child has no other children receiving Medicaid.

Advisors must review Form H0050, Parent Profile Questionnaire, with the individual to ensure no items are blank, that the individual provided complete and current information, and entered the information in the Absent Parent logical unit of work (LUW). The Texas Integrated Eligibility Redesign System (TIERS) automatically sends the referral to the OAG.

A-1123 Updates to Child Support Referrals

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Advisors must advise the client to report new information about the absent parent(s), review the information previously submitted for accuracy, and update items as needed. The OAG will receive the update automatically.

A-1124 TANF

Revision 15-4; Effective October 1, 2015

After certification, TANF individuals must remit to the OAG all child support payments received for a certified child. Individuals should be given sufficient copies of Form H1710, Payment Identification, and OAG self-addressed envelopes, if payments are being made or might be made. When the individual receives a child support payment from an absent parent following certification, the individual must:

- write on the check or money order "Deposit Only - State Treasury" and **not** endorse the check or money order;
- include Form H1710 with the check or money order; and
- send it to the Texas Child Support Disbursement Unit, P.O. Box 659791, San Antonio, Texas 78265-9941.

If child support is intended for a child on TANF and one on Supplemental Security Income (SSI), the individual must remit the payment to the OAG for proration and distribution to occur.

If the individual turns in child support payments to the local office, advisors must:

- forward the payment(s) to the Child Support Disbursement Unit; and
- give the individual a copy of Form H4100, Money Receipt.

Advisors must send Form H1701, Child Support, TANF Foster Care and TANF/Medicaid Case Information Exchange, including the amounts and months involved, to the OAG if the advisor becomes aware that the individual did not remit a child support payment. Advisors should follow policy in A-1140, Noncooperation with Child Support Program Requirements, to sanction the individual for noncooperation. If the individual indicates they will continue to keep child support received from the absent parent, the advisor should follow policy in B-700, Claims, and process a claim for the month(s) of unreported income.

If the OAG becomes aware that the individual received child support and did not remit the payments, the child support officer notifies the advisor on Form H1701. The advisor must process a claim for the unreported income.

TANF-SP

The household must not be required to remit any child support collected on behalf of a non-mutual child.

Related Policy

Remitting Cash Medical Support Payments to the Third-Party Resources (TPR) Unit, A-861.5
Child Support, A-1326.2

A-1125 OAG Distribution

Revision 15-4; Effective October 1, 2015

TANF

After individuals are certified for TANF, they must send all child support payments received to the OAG Child Support Division. The OAG:

- sends the $75 disregard to the individual;
- reimburses the state for TANF paid to the individual; and
- sends HHSC the monthly interface file of child support collections for TANF recipients.

HHSC uses the information to determine whether the collection exceeds the grant plus the disregard, and to determine grant in jeopardy if it exceeds the grant.

If the individual receives child support for an SSI child in the household, the OAG will distribute (directly to the individual) the prorated share of support intended for the SSI child.

The month after the OAG receives a child support payment, the OAG will send the individual up to $75 (disregard payment). The amount sent is the lesser of:

- the court-ordered payment amount,
- the amount the OAG received during a given month, or
- $75.

When the OAG receives a child support collection that exceeds the grant plus unreimbursed assistance, the excess is sent to the individual. Form H1714, Notice of Grant Jeopardy; Form H1715, Notice of Excess Payment; or Form H1717, Notice of Grant Jeopardy/Excess Payment — Denial, will notify the advisor of the date and amount of the payment.

A grant-in-jeopardy EDG may be generated for EDGs involving SSI children. In processing the grant-in-jeopardy, TIERS determines whether the prorated share of child support exceeds the TANF grant, minus the disregard. If the prorated share exceeds the TANF grant, minus the disregard, TIERS will deny the EDG. If the amount does not exceed the TANF grant, TIERS will allow the TANF EDG to continue.

Example: The household consists of a caretaker and one child who receives TANF and one child who receives SSI.

-	$300	child support for both children
-	-150	will go directly to SSI child
-	150	child support for TANF child
-	- 75	disregard
-	$75	does not exceed TANF for a caretaker and one child; the state retains the child support

Note: If the individual appeals the action described in A-852, Automated Process, and receives continued benefits, the advisor must count the excess payment as income during the appeal period if the advisor anticipates that the child support payments will continue.

Related Policy

Automated Process, A-852
Child Support, A-1326.2
$75 Disregard Deduction, A-1422
Child Support Systems, C-830

A-1130, Explanation of Good Cause

Body

A-1130 Explanation of Good Cause

Revision 26-2; Effective April 1, 2026

TANF, TP 08 and TA 31

Good cause allows people to access benefits safely. It provides an exemption from cooperating with the OAG's child support and medical support requirements.

Explain the family violence option and good cause exemption to all households applying for benefits, when an interview is conducted. Use of Child Support Eligibility Requirements Family Violence and Good Cause FAQs (PDF), to explain the good cause exemption from the child support and medical support requirements. Include the situations that justify good cause and the required verifications in the explanation. Explain that the applicant does not have to cooperate with child support or medical support requirements if they can prove that cooperation is not in the child's best interest.

A claim of good cause must be made separately for each absent parent. Notify the OAG of the applicant's good cause claim. This notification is sent from HHSC to the OAG through an automated interface once staff enter the information into the eligibility determination system and the case is disposed.

After explaining Form H1712 to the applicant:

- Review Part I of Form H1713, Service Plan for Family Violence Option and Report of Good Cause, with the applicant during the interview.
  - Complete only Part I of Form H1713 if the applicant indicates on this form that they **do not** want to claim good cause.
  - If the applicant wants to continue to claim good cause, continue completing Part II and Part III, where applicable, of Form H1713.
- Complete Part II Assessment Referral of Form H1713 if the applicant wants to claim good cause for family violence.
  - Make an assessment referral to a family violence specialist using Part II of Form 1713.
  - The family violence specialist makes a recommendation of good cause for reasons of family violence using Form H1706, Good Cause Recommendation and Family Violence Exemption.
- Complete Part III of Form H1713 to show the good cause reason and determination date.

Once the family violence specialist makes a recommendation of good cause on Form H1706, complete Part III of Form H1713 and send the form to the local child support office and HHSC Family Violence Program (FVP) staff to report the final decision.

Note: The eligibility determination system automatically notifies the local child support office of the good cause determination through the OAG interface when the EDG is disposed.

TP 08 and TA 31

Do not require an interview. Send Form H1712 and Form H1713 by mail to the household to determine if good cause applies if unable to reach the household by phone.

Related Policy

Good Cause for Family Violence Option, A-1131.1

A-1131 Good Cause Situations

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Good cause exists when:

- a child was conceived as a result of incest or rape;
- a child or caretaker may be physically harmed;
- a child or caretaker may be emotionally harmed to the extent that the caretaker's capacity to adequately care for the child is impaired; or
- legal proceedings for the child's adoption are pending before a court or a licensed or private social agency is helping the individual decide whether to keep the child or relinquish the child for adoption.

Note: This issue must not have been under discussion more than three months and staff must update the absent parent referral if the issue remains unsolved beyond the third month.

A-1131.1 Good Cause for Family Violence Option

Revision 26-2; Effective April 1, 2026

TANF, TP 08 and TA 31

Cooperating with the OAG's child and medical support requirements could pose a potential safety risk for family violence victims and their children. HHSC and OAG allow good cause for family violence to not comply with child and medical support requirements. Explain and offer the family violence option at each application and redetermination.

Staff must:

- explain Explanation of Child Support Eligibility Requirements Family Violence and Good Cause FAQs (PDF), and give a copy of the form to the applicant;
- review Part I of Form H1713, Acknowledgement of Family Violence Good Cause Option and Contact Resource, with the applicant; and
- use Part II of Form 1713 to make a referral to a family violence specialist if the applicant wants to claim good cause for reasons of family violence.

A list of family violence shelters is searchable in the eligibility determination system and on the HHS Family Violence Program page. Give the applicant the National Domestic Violence Hotline number if no shelter serves their area to help them locate the closest family violence service provider. The number is 800-799-7233 (800-799-SAFE) or 800-787-3324 TTY for people who are deaf.

If the applicant wants to claim good cause for not complying with TANF or Medicaid child and medical support requirements due to family violence:

- the applicant arranges to speak with the referred family violence specialist to discuss their need to claim good cause;
- the family violence specialist makes the good cause recommendation after they complete Form H1706, Good Cause Recommendation and Family Violence Exemption, and returns the form to the applicant or HHSC to use as verification;
- provide the applicant a confidential phone interview with the family violence specialist from the local HHSC eligibility office for face-to-face interviews at a local HHSC eligibility office; and
- in the face-to-face scenario, the Form H1706 is not required, and staff use client statement as verification.

Continue to process the TANF or Medicaid EDG. Collect absent parent information verbally or by pending the EDG for the Form H0050, Parent Profile Questionnaire. Remind the applicant that HHSC requires a completed Form H0050 if the family violence specialist does not recommend good cause or the applicant decides not to pursue good cause. If the applicant does not pursue good cause, they must complete and return Form H0050 or provide absent parent information before staff can approve the TANF or Medicaid EDG.

Note: By collecting the absent parent information or pending the EDG for the information at the time of application, staff can process the application whether or not the H1706 supports the good cause claim.

Allow the applicant at least 10 days to return Form H1706, Form H1713 and Form H0050. Certify the EDG, if otherwise eligible, without the Form H1706, if not returned or if Form H1706 does not support the good cause claim.

Staff requirements for Form H1713 are:

- complete Part II and Part III of Form H1713;
- send a copy to the local child support office; and
- send a copy to the family violence coordinator by one of the following methods to report the final decision:
  - Interagency mail: Family Violence Coordinator, Mail Code 2010
  - Regular mail: Family Violence Coordinator 909 W. 45th St., Mail Code 2010 Austin, TX 78751; or
  - Email: Send completed and scanned documents only to the HHSC Family Violence Mailbox.

Once the good cause claim is established, review the claim at each redetermination. Update the absent parent referral if the recipient stops claiming good cause. Do this by removing the good cause indicator to allow the OAG to help the family get child or medical support services for their children. If the recipient continues to claim good cause, continue to uphold good cause.

TP 08 and TA 31

Do not require an interview. Staff send Form H1712 and Form H1713 by mail to the household to determine if good cause applies if unable to reach the household by phone.

A-1131.2 Good Cause Related to Adoptions, Rape or Incest

Revision 15-4; Effective October 1, 2015

TANF and TP 08

If an individual claims good cause based on an adoption, rape, or incest, advisors must:

- allow individuals 20 days to provide evidence;
- extend the deadline for evidence if additional time is needed to obtain the necessary information;
- document the reason for extending the deadline and obtain supervisory approval; and
- flag the case and evaluate the evidence when received and recommend either that the individual:
  - has good cause for not cooperating and the OAG should not continue child support locate and enforcement efforts; or
  - does not have good cause for not cooperating and the OAG should continue child support locate and enforcement efforts.

Note: For adoption situations, the issue must not have been under discussion for more than three months. If the issue is unresolved beyond the third month, staff must update the absent parent referral.

A-1140, Noncooperation with Child Support Program Requirements

Body

Revision 15-4; Effective October 1, 2015

TANF and TP 08

At initial certification and redetermination or incomplete reviews, the advisor must determine whether the individual failed to cooperate with child support requirements.

The advisor determines noncooperation when:

- an individual fails to cooperate with child support requirements without good cause (see A-1120, Child Support Program Requirements and Procedures, for individual responsibilities); or
- HHSC receives Form H1708-A, Report of Noncooperation (Automated), from the OAG via the weekly interface.

Medical Programs except TP 08

There is no penalty for noncooperation for Medical Programs. Advisors do not take any action on an individual who volunteers to receive child and medical support services but later noncomplies.

A—1141 Sanctions for Noncooperation

Revision 16-2; Effective April 1, 2016

TANF and TP 08

The Child Support Division of the OAG notifies HHSC via a weekly interface when an individual fails to cooperate with child support or medical support. Upon receipt of the notice of child support noncooperation, HHSC must take action to process the noncooperation within five workdays. See A-2140, Full-Family Sanction, and A-2150, Pay for Performance.

TANF

Adult TANF recipients, second parents and minor parents certified as adults, payees or disqualified adults are required to sign Form H1073, Personal Responsibility Agreement, and cooperate with child support requirements. Failure to do so results in a full-family sanction. If the TANF recipient or payee has more than one TANF EDG and fails to cooperate with child support requirements, the sanction applies to all of their TANF EDGs. See A-2140 and A-2150.

TP 08

Parents and caretaker relatives receiving TP 08 must cooperate in establishing medical support. Failure to cooperate with requirements results in the loss of medical coverage for the noncooperating adult.

The advisor must deny a noncooperating adult's TP 08 EDG. See A-1142, Noncooperation Situations.

Medical Programs except TP 08

Recipients applying for Children's Medicaid programs, including TP 40 for a pregnant teen under age 19, are not required to cooperate with child support requirements. Therefore, there is no penalty for noncooperation. Recipients may volunteer for child support services.

A—1142 Noncooperation Situations

Revision 15-4; Effective October 1, 2015

TANF and TP 08

If a child support noncooperation is received on …	and the household does not have good cause, then …
• a denied EDG in a TANF cash benefit month,	• TIERS identifies the noncooperation; and • sends Form TF0001, Notice of Case Action, advising the household of the noncooperation and how to cooperate. **Note:** If the household fails to cooperate by the last calendar day of the second month, the household will be subject to pay for performance requirements when they reapply for TANF.
• a denied case in a non-TANF cash benefit month,	no action is required.
• an active TANF or TP 08 EDG, the month after the child is no longer in the home, and the noncooperation date is after the date the child was removed from the EDG,	no further action is required.
• an EDG already sanctioned for a child support noncooperation on a different absent parent,	TIERS sends Form TF0001 advising the household of the noncooperation and how to cooperate. **Note:** The OAG will not issue Form H1701, Child Support, TANF Foster Care and TANF/Medicaid Case Information Exchange, until the individual cures all noncooperations.
• an active TP 08 EDG,	TIERS denies the noncooperating adult's TP 08 EDG.
• an active EDG and the child receives SSI, • a TANF-SP EDG with a child in the household who is deprived due to the absence of a parent, • an active TANF cash EDG and the individual and absent parent have reconciled and are in the home together, or • an active TP 08 EDG and the individual and absent parent have reconciled and are in the home together,	refer to A-2140, Full-Family Sanction, to impose a full-family sanction. If the household fails to cure the noncooperation before the last day of the second noncooperation month, they will need to reapply under pay for performance. TIERS denies the noncooperating adult's TP 08 EDG.

Note: The advisor must determine whether the individual has good cause for not cooperating with child support requirements using policy in A-1130, Explanation of Good Cause. If the individual has good cause, the advisor should not impose a full-family sanction.

Related Policy

Explanation of Good Cause, A-1130
Noncooperation with Child Support Program Requirements, A-1140
Good Cause for Child Support Noncooperation, A-2122.3
Full-Family Sanction, A-2140
Pay for Performance, A-2150

A-1150, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Advisors must verify all good cause claims.

A—1151 Verification Sources

Revision 15-4; Effective October 1, 2015

TANF and TP 08

The following are acceptable verification sources or evidence for:

- Emotional or Physical Harm for Individuals — a written recommendation from a family violence specialist. The specialist must be an employee of a family violence program that contracts with HHSC. The family violence specialist must complete Form H1706,Good Cause Recommendation and Family Violence Exemption, which serves as verification for the good cause claim.
- Incest or Rape — a birth certificate or medical or law enforcement records indicating the circumstances surrounding the child's birth.
- Adoption or Pending Adoption — a court document, other related records, or written statement of the facts from the social services agency.

Related Policy Questionable Information, C-920 Providing Verification, C-930

A-1160, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Advisors must document:

- that the individual cooperated with the child support requirements;
- every aspect of the good cause investigation, the determination, the basis for the determination, and the evidence provided;
- determination made at each re-evaluation of good cause, which must occur at each periodic review; and
- the reason an individual cannot provide minimum information on an absent parent.

TANF

Advisors must document the name and last known address of the legal and/or biological father of an unborn child if the mother receives TANF.

Medical Programs except TP 08

Advisors must document that the individual did not want to volunteer for child/medical support services.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

A-1200, Resources

A-1210, General Policy

Body

Revision 24-2; Effective April 1, 2024

TANF, SNAP, Children on TP 32 and Children on TP 56

Resources are assets or possessions that are either countable or exempt, depending on the program and Type of Assistance (TOA). There are liquid and nonliquid resources. Liquid resources are those that are readily available, such as cash, checking or savings accounts, debit accounts, savings certificates, stocks, or bonds. Nonliquid resources are those that cannot be readily converted to cash, including vehicles, buildings, land, or certain other property. Count the equity value of all resources, liquid and nonliquid, unless otherwise specified or listed as exempt. The equity value is the fair market value (FMV) of an item minus all money owed on the item and the cost associated with the item's sale or transfer.

Count resources of:

- an alien's sponsor;
- disqualified people;
- stepparents in TANF households;
- members of the TANF certified group;
- members of the SNAP EDG; and
- children on TP 32 and TP 56 EDGs.

If payments exempted as resources are kept in a separate account, those payments remain exempt. If the money is placed in an interest-bearing account, the interest must be counted as income in the month received. If the money is combined with money that is countable, exempt the excluded funds for six months from the date the funds are combined. After six months, the total amount of combined funds should be counted as an available resource.

Related Policy

Resources of an Alien's Sponsor, A-1245
Resources of Stepparents, A-1247

SNAP

Categorical eligibility extends to any household authorized to receive services funded by the TANF program. The TANF non-cash (TANF-NC) program offers various services such as family planning, adult education, prevention and treatment of substance abuse, and employment services. Households must pass an income and resource test for determination of categorical eligibility based on receipt of TANF-NC services.

To meet the resource test, the household's countable liquid resources plus excess vehicle value must be $5,000 or less. The excess vehicle value can be:

- Up to $22,500, of the FMV for the highest valued countable vehicle is exempt. The excess over $22,500 FMV is counted toward the combined resource limit.
- Up to $8,700 FMV for all other countable vehicles is exempt. The excess over $8,700 FMV is counted toward the combined resource limit. **Note:** Refer to vehicle policy for more reasons a vehicle can be exempted.

Once the recipient is authorized for TANF-NC services based on the initial resource test, all other nonliquid resources are exempt. Regular TANF policy must be followed when determining countable liquid resources within TANF-NC. Most resources are not applicable to SNAP.

Related Policy

Limits, A-1220
Prepaid Burial Insurance, A-1233.2
Vehicles, A-1238
How to Determine Fair Market Value of Vehicles, A-1238.5
General Policy, A-1310
Categorically Eligible Households, B-470
What to Report, B-621

Medical Programs Except Children on TP 56 and Children on TP 32

Resources are not considered a factor in determining eligibility.

Children on TP 56 and Children on TP 32

Resources are considered as a factor in determining eligibility for children on TP 56 and TP 32.

Exception: Do not consider resources when determining a newborn's eligibility for TP 56 when the newborn's mother was eligible for TP 56 or TP 32 at the time of the newborn's birth.

A—1211 Requirement to Pursue Resources

Revision 15-4; Effective October 1, 2015

TANF

An individual must pursue all resources to which the individual is legally entitled unless it is unreasonable to pursue the resource. Advisors should develop a plan with the individual to pursue the potential resource and allow reasonable time (at least three months) to pursue the resource.

Advisors should use the comment section of Form TF0001, Notice of Case Action, to inform the individual of the requirement to pursue the resource, including the time the individual has to pursue it, and the resource is not considered available during that time.

If the individual does not pursue the resource within a reasonable time, the Eligibility Determination Group (EDG) is denied.

Exception: The individual does not have to pursue a resource if it would be unreasonable. It is unreasonable to pursue a resource if any of the following conditions exist:

- The cost to the individual to pursue the resource exceeds the potential resource's value or causes the individual financial hardship;
- Pursuing the resource would endanger the individual's health or safety; or
- Legal action is required, but a private attorney or legal service refuses to accept the case. The individual must make a reasonable effort to obtain legal assistance.

SNAP

Individuals receiving SNAP benefits do not have to pursue resources.

Note: Pursuing resources could help an individual become self-sufficient, and individuals should be provided examples of resources they might be entitled to receive.

A—1212 Transferring Resources

Revision 13-2; Effective April 1, 2013

A—1212.1 Penalties for Transferring Resources

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Households are ineligible if, within three months before application or any time after certification, the household transfers a countable resource for less than its fair market value to qualify for assistance. This penalty applies if the total of the transferred resource added to other resources affects eligibility.

Resources transferred between members of the same TANF/SNAP household do not affect eligibility. If spouses separate and one spouse transfers individual property, the other spouse's eligibility is not affected.

Children on TP 56 and Children on TP 32

Applicants or individuals who transfer resources to qualify for assistance must not be denied.

A—1212.2 How to Determine Intent

Revision 15-4; Effective October 1, 2015

TANF and SNAP

In determining an individual's intent for transferring resources for TANF and SNAP benefits, staff must consider the following:

- How recent was the transfer of property? A recent transfer may indicate the household transferred the resource to qualify for benefits.
- How did the applicant support the household after transferring the resource? If the applicant was self-supporting or supported by the person who received the property, then the applicant's intent was to have support rather than qualify for benefits.
- How did the applicant transfer the property? If the applicant loaned the property but cannot recover its value after making a reasonable effort, the applicant is eligible.
- Special or unpredictable hardships that prevent the individual from making payments for the transferred resource do not affect eligibility. The supervisor and program manager must approve these situations.

A—1212.3 Length of Denial Period

Revision 24-2; Effective April 1, 2024

TANF and SNAP

Base the length of denial on the amount of the transferred resources that exceed the resource maximum when added to other countable resources.

Amount in Excess of Resource Limit	Denial Period
$.01 to $249.99	1 month
$250 to $999.99	3 months
$1,000 to $2,999.99	6 months
$3,000 to $4,999.99	9 months
$5,000 and more	12 months

Examples:

TANF: A two-person household has $1,250 in a bank account and transfers ownership of a car worth $5,650. Exempt the first $4,650 of the vehicle's FMV and add the remaining $1,000 to the$1,250 bank account. Subtract the $1,000 resource limit from the total. Use $1,250 to determine the number of months of ineligibility. The household is ineligible for six months.

SNAP: A two-person household has $2,000 in a bank account and transfers ownership of a car worth $26,500. Exempt the first $22,500 of the vehicle's FMV and add the remaining $4,000 to the $2,000 bank account. Subtract the $5,000 resource limit from the total. Use $1,000 to determine the number of months of ineligibility. The household is ineligible for six months.

A—1212.4 Beginning the Denial Period

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The denial period begins in the application month unless the household is already certified when the advisor discovers the transfer.

Once the household is certified, the advisor must send a notice of adverse action and follow adverse action procedures. The advisor must begin the denial period the first month after the month the notice of adverse action expires unless the individual requests a fair hearing and receives continued benefits.

A-1220, Limits

Body

Revision 15-4; Effective October 1, 2015

TANF

A household is not eligible for benefits if the total value of accessible resources is over $1,000.

A household is not eligible for benefits if resources are over the limit on or after the first interview date.

If a TANF applicant/recipient fails to provide resource verification for TANF, the advisor must:

- deny the TANF application, and
- process the application for non-public assistance (NPA) SNAP eligibility.

SNAP

A household is not eligible for benefits if the total value of countable resources (liquid resources and excess vehicle value) is over $5,000.

A household is not eligible for benefits if resources are over the limit on or after the first interview date. Additionally, striker households are ineligible if resources are over the limit the day before the strike.

Children on TP 32 and Children on TP 56

A child is not eligible for benefits if the total value of accessible resources is over:

- $3,000 in households with a member who is aged or has a disability and meets relationship requirements; or
- $2,000 for all other households.

Advisors must use the SNAP definitions of aged and disability found in B-431, Definition of Elderly, and B-432, Definition of Disability. The individual who is aged or has a disability does not have to be part of the Medical Programs budget group, but must meet relationship requirements.

A child is not eligible for benefits if resources are over the limit on the process date. In determining eligibility for a prior month, the household is not eligible if resources are over the limit anytime during the prior month.

Related Policy

General Policy, A-1210
Prepaid Burial Insurance, A-1233.2
Vehicles, A-1238
How to Determine Fair Market Value of Vehicles, A-1238.5
General Policy, A-1310
Categorically Eligible Households, B-470

A-1230, Types of Resources

Body

Revision 03-3; Effective April 1, 2003

A-1231 Accounts

Revision 07-4; Effective October 1, 2007

A-1231.1 Bank Accounts

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Advisors must count the cash value of checking and savings accounts unless exempt for another reason.

Related Policy

Payments Exempt as a Resource While Being Considered Income, A-1243
Inaccessible Resources, A-1241

A-1231.2 Debit Accounts

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Advisors must count the cash value of benefits in a debit account, less amounts deposited in the current month, as a resource. Government benefit payments may be deposited into a debit account. Advisors must verify the balance in the account using the most current information.

The most common debit accounts established for deposit of government benefits are the:

- Electronic Benefit Transfer (EBT) cash accounts for TANF benefits;
- unemployment insurance benefits (UIB) debit accounts;
- Texas debit card accounts for child support payments, Office of Attorney General (OAG);
- debit card accounts for child support payments from other states; and
- Direct Express card debit accounts for Social Security; Retirement, Survivors and Disability Insurance (RSDI); or Supplemental Security Income (SSI) benefits payments.

This list is not intended to be all inclusive as more agencies and businesses move toward the use of debit cards to issue benefits.

Account inquiry is accessible to:

- TANF recipients by calling the Lone Star Help Desk automated voice response system at 1-800-777-7EBT (1-800-777-7328);
- UIB recipients online at https://www.usbankreliacard.com/ or at any automated teller machine (ATM) free of charge;
- child support recipients online at www.EPPICard.com;
- Social Security recipients online at www.USDirectExpress.com, by calling 1-888-741-1115, or balance information may be obtained free of charge at any ATM that displays the MasterCard® logo.

Exception: See A-1248, Resources of TANF and SSI Recipients.

Related Policy

Retirement, Survivors, and Disability Insurance (RSDI), A-1324.16
Supplemental Security Income (SSI), A-1324.17
Temporary Assistance for Needy Families (TANF), A-1324.18
Unemployment Compensation, A-1324.19
Counting Child Support, A-1326.2.1
Client Inquiries, B-382

A-1231.3 Individual Development Accounts (IDAs)

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Staff must use the following policy to determine whether an IDA is a countable or exempt resource.

TANF IDAs — TANF IDAs must be used for one of the following purposes:

- paying for a college education,
- purchasing a home, or
- starting a business.

The household is not required to be a TANF recipient to qualify for an IDA, but the household must be financially needy and have a child living with the custodial parent or other adult relative who meets the TANF relationship criteria or the household must consist of a pregnant woman.

The household is considered financially needy if the household is eligible to receive TANF, SNAP, or any Medical Program except TP 56. For TP 56, the household is considered financially needy if its gross income is below 185 percent of the Federal Poverty Income Limit (FPIL).

Any earnings, including Earned Income Tax Credit (EIC), deposited in a TANF IDA must be excluded from resources. Any interest earned on the account must be excluded from resources. Any deposits into an IDA not made with earnings, or withdrawals from an IDA that are not made for an allowable qualifying purpose, should count as a resource.

Assets for Independence Act (AFIA) IDAs — AFIA IDAs are funded and authorized under the AFIA and must meet one of the same qualifying purposes as TANF IDAs. Any earnings, including EIC, deposited in an AFIA IDA must be excluded from resources. Any interest earned on the account must also be excluded from resources. Any deposits into an IDA not made with earnings, or withdrawals from an IDA that are not made for an allowable qualifying purpose, should count as a resource.

Other IDAs — These IDAs do not meet one of the qualifying purposes of paying for a college education, purchasing a home, or starting a business and should be counted as a resource. The interest earned on these accounts must be counted as unearned income.

For any type of IDA, matched funds are not counted as a resource, as they are not accessible to the household.

Exception: IDAs are exempted if Long Term Care certifies them as meeting the Social Security criteria for a Plan to Achieve Self-Sufficiency (PASS).

A-1231.4 Retirement Accounts

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

A retirement account is one in which an employee and/or the employer contributes money for retirement. There are several types of retirement plans.

Some of the most common plans authorized under Section 401(a) of the Internal Revenue Services (IRS) Code are the 401(k) plan, Keogh, Roth individual retirement account (IRA), and a pension or traditional benefit plan. Common plans under Section 408 of the IRS Code are the IRA, Simple IRA, and Simplified Employer Plan.

- A 401(k) plan allows an employee to postpone receiving a portion of current income until retirement.
- An IRA is an account in which an individual contributes money to supplement the individual's retirement income (regardless of the individual's participation in a group retirement plan).
- A Keogh plan is an IRA for a self-employed individual.
- A Simplified Employee Pension (SEP) plan is an IRA owned by an employee to which an employer makes contributions or an IRA owned by a self-employed individual who makes contributions for the individual's self.
- A pension or traditional defined benefit plan is employer-based and promises a certain benefit upon retirement regardless of investment performance.

The following retirement accounts or plans are excluded:

- Accounts established under Internal Revenue Code of 1986, Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), 501(c)(18);
- Plans established under the Federal Thrift Savings Plan, Section 8439, Title 5, United States Code; and
- Other retirement accounts determined to be tax exempt under the Internal Revenue Code of 1986.

Any other retirement accounts not established under plans or codes listed above are counted.

Related Policy

Lump-Sum Payments, A-1242

A-1231.5 Education Tuition Savings Plan

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Internal Revenue Service Code, Section 529 and 530, Coverdell Education Tuition Savings Plans, which provide special tax benefits for school tuition savings accounts, are exempt.

Section 529 qualified tuition programs allow owners to prepay a student's education expenses or contribute to an account to pay those expenses. Examples of Section 529 accounts are:

- Texas College Savings Plan;
- LoneStar 529 Plan; and
- Texas Guaranteed Tuition Plan (formerly the Texas Tomorrow Fund).

A Coverdell Education Savings Account is a trust or custodial account set up in the U.S. for the sole purpose of paying qualified education expenses for the designated beneficiary of the account. There is no limit to the number of accounts that can be established for a beneficiary. The designated beneficiary must be under age 18 at the time the account is established. The plan may be for elementary school through college.

A-1231.6 Achieving a Better Life Experience (ABLE) Accounts

Revision 17-1; Effective January 1, 2017

Achieving a Better Life Experience (ABLE) programs allow individuals who become blind or disabled before age 26 to establish tax-free savings accounts for the designated beneficiary's disability-related expenses.

TANF, SNAP, Children on TP 32 and Children on TP 56

Funds held in an ABLE account are excluded from countable resources when determining eligibility.

Related Policy

Achieving a Better Life Experience (ABLE) Accounts; A-1326.25

A-1231.7 School-Based Savings Accounts

Revision 17-4; Effective October 1, 2017

All Programs

School-Based Savings Accounts are accounts set up by students or their parents at financial institutions that partner with school districts. The accounts are intended to help students save for higher education.

TANF, Children on TP 32 and Children on TP 56

Funds in School-Based Savings Accounts are exempt up to an amount set by the Texas Higher Education Coordinating Board (THECB) each year. The current exempt amount is $11,896. Count any excess over the exempt amount as a resource.

Note: This amount is updated annually.

SNAP

The total amount of funds in a School-Based Savings Account is exempt.

Related Policy

School-Based Savings Accounts, A-1326.26

A-1232 Government Payments

Revision 07-4; Effective October 1, 2007

A-1232.1 Crime Victim's Compensation Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Crime victim's compensation payments are exempt from resources.

A-1232.2 Federal Tax Refunds and Earned Income Tax Credits (EIC)

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Federal tax refunds and EIC payments are exempt from resources for a period of 12 months after receipt.

Related Policy

Federal Tax Refunds and Earned Income Tax Credits (EIC), A-1323.5.1

A-1232.3 Energy Assistance Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments or allowances made under any federal law for the purpose of energy assistance are exempt.

Related Policy

Energy Assistance, A-1326.3

A-1232.4 Government Disaster Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Federal disaster payments and comparable disaster assistance provided by states, local governments, and disaster assistance organizations if the household is subject to legal penalties when the funds are not used as intended (including temporary employment of six months or less for disaster-related work, paid under the Workforce Innovation and Opportunity Act and funded by the National Emergency Grant) are exempt.

Examples:

- Payments by the Individual and Family Grant Program or Small Business Administration to rebuild a home or replace personal possessions damaged in a disaster.
- Payments from the Federal Emergency Management Agency (FEMA) to assist with rent.

Related Policy

Government Disaster Payments, A-1324.3

A-1232.5 Transitional Living Allowance

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Transitional living allowances are exempt.

Related Policy

Transitional Living Allowance, A-1324.5

A-1232.6 Native and Indian Claims

Revision 20-3; Effective July 1, 2020

TANF, SNAP, Children on TP 32 and Children on TP 56

The following payments resulting from Public Laws are exempt:

- Payments to Grand River Band of Ottawa Indians (Public Law [PL] 94-540).
- Payments to Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians received according to the Maine Indian Claims Settlement Act of 1980 (PL 96-420, Section 9(c)).
- Payments to members of the Seneca Nation (PL 101-503).
- Payments to Confederated Tribes and Bands of the Yakima Indian Nation and the Apache Tribe of the Mescalero Reservation, received from the Indian Claims Commission (PL 95-433).
- Payments made under the Sac and Fox Indian Claims Agreement (PL 94-189).
- Payments received by certain Indian tribal members under PL 94-114, Section 6, for submarginal lands held in trust by the United States.
- Payments from Indian lands held jointly with the tribe or land that can be sold only with approval of the Bureau of Indian Affairs.

SNAP and TANF

The following distributions and payments are exempt:

- Distributions from native corporations made under the Alaska Native Claims Settlement Act (ANCSA) (PL 92-203 and Section 15 of PL 100-241), as follows:
  - cash up to $2,000 per person per calendar year;
  - stocks;
  - a partnership interest;
  - land or interest in land; or
  - an interest in a settlement trust.
- Payments (and any initial purchases made with such funds) distributed by the Secretary of the Interior to families or individual tribal members (PL 93-134) including:
  - tribal trust funds distributed to individual members of an Indian tribe (PL 98-64);
  - judgment funds up to $2,000 per year, per person, granted to a tribe because of claims against the United States and held in trust or distributed per capita (PL 93-134 as amended by PL 97-458);
  - payments up to $2,000 per year to heirs of deceased Indians made under the Old Age Assistance Claims Settlement Act (PL 98-500); and
  - payments distributed per capita to or held in trust for members of any Indian tribe under PL 92-254.

SNAP

The following four types of property belonging to a member of a federally recognized Indian tribe are exempt:

- Property, which may be real property and improvements, that is held in trust located on a reservation, including any federally recognized Indian tribe reservation, pueblo or colony. Property may be located on former reservations in Oklahoma, in Alaska native regions established by the Alaska Native Claims Settlement Act, and on Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs.
- For any federally recognized tribe not listed in the previous item, property located on a past federally recognized reservation.
- Ownership interests in rents, leases, royalties, or usage rights related to natural resources that are federally protected by the Bureau of Indian Affairs.
- Ownership or usage rights to property not in the previous items that have unique religious, spiritual, traditional or cultural significance, or ownership or usage rights that allow the continuation of the Indian lifestyle according to tribal law or custom.

A-1232.7 Payments to Children of Vietnam Veterans

Revision 03-7; Effective October 1, 2003

A-1232.7.1 Payments to Children of Vietnam Veterans Who Are Born with Spina Bifida

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Exempt Veterans Affairs (VA) payments made under PL 104-204.

A-1232.7.2 Payments to Children of Women Vietnam Veterans Born with Certain Birth Defects (Public Law 106-419)

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Exempt VA payments made under PL 106-419.

A-1232.8 Payments to Civilians Relocated During Wartime

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments to civilians relocated during wartime made under Title I of PL 100-383 are exempt. These payments are made to Aleuts or individuals of Japanese ancestry (or their heirs) who were relocated during World War II.

A-1232.9 Payments to Victims of Nazi Persecution

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments made to individuals because of their status as victims of Nazi persecution are exempt.

A-1232.10 Radiation Exposure Compensation Act Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments provided from the Radiation Exposure Compensation Act, PL 101-426, are exempt.

A-1232.11 Payments to World War II Filipino Veterans and Spouses

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Under the American Recovery and Reinvestment Act of 2009 (Division A, Title X, Section 1002), some World War II Filipino veterans who served in the military forces of the Government of Commonwealth of the Philippines, and their spouses, are authorized to receive one-time lump sum payments of up to $15,000.

These payments are exempt.

A-1232.12 Relocation Assistance

Revision 25-3; Effective July 1, 2025

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments provided by the following are exempt:

- The Uniform Relocation Assistance and Real Properties Acquisition Act of 1970.
- PL 93-531, relocation assistance payments to members of the Navajo and Hopi tribes.

Related Policy

Relocation Assistance, A-1324.15

A-1232.13 Relative and Other Designated Caregiver Program Payments

Revision 19-1; Effective January 1, 2019

TANF, SNAP, Children on TP 32 and Children on TP 56

There are two types of Relative and Other Designated Caregiver Program Payments issued by DFPS. These include:

- Kinship Reimbursement payments; and
- Post-Permanent Managing Conservatorship Annual Reimbursement payments.

The remaining balance of both of these types of payments is considered a resource in the month(s) after receipt.

Related Policy

Relative and Other Designated Caregiver Program Payments, A-1324.21

A-1233 Insurance

Revision 03-5; Effective July 1, 2003

A-1233.1 Life Insurance

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The cash value of life insurance policies is exempt.

A-1233.2 Prepaid Burial Insurance

Revision 21-2; Effective April 1, 2021

TANF and SNAP

Exempt the full cash value of a prepaid burial insurance policy, funeral plan or funeral agreement for each household member.

Children on TP 32 and Children on TP 56

Exempt up to $7,500 cash value of a prepaid burial insurance policy, funeral plan, or funeral agreement for each certified household member. Count the cash value exceeding $7,500 as a liquid resource.

The person's statement of cash value should be accepted unless the amount is questionable or close to the maximum allowable limits.

Related Policy

General Policy, A-1210
Limits, A-1220
Vehicles, A-1238
How to Determine Fair Market Value of Vehicles, A-1238.5
General Policy, A-1310
Categorically Eligible Households, B-470

A-1234 Noneducational Loans

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Financial assistance is considered as a loan if:

there is an understanding the money will be repaid, and

the individual can reasonably explain how the loan will be repaid.

These loans are exempt from resources, but assistance that is not considered a loan, such as a contribution, is counted as unearned income.

Related Policy

Cash Gifts and Contributions, A-1326.1
Loans (Noneducational), A-1326.7

A-1235 Personal Possessions

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Exempt personal possessions.

A-1236 Property

Revision 03-1; Effective January 1, 2003

A-1236.1 Burial Plots

Revision 23-1; Effective Jan 1, 2023

TANF, SNAP, Children on TP 32 and Children on TP 56

Exempt one burial plot per household member.

Related Policy

Prepaid Burial Insurance, A-1233.2

A-1236.2 Homestead

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The usual residence and surrounding property not separated by property owned by others is exempt. The exemption remains in effect if public rights of way, such as roads, separate the surrounding property from the home. The homestead exemption applies to any structure the individual uses as a primary residence, including additional buildings on contiguous land, a houseboat, or a motor home, as long as the household lives in it. If the household does not live in the structure, the structure is counted it as a resource. Houseboats and motor homes count according to vehicle policy, if not considered the household's primary residence or otherwise exempt. The equity value of extra buildings counts unless the buildings are exempt for another reason.

For households that currently do not own a home, but own or are purchasing a lot on which they intend to build, the lot and partially completed home are exempt.

TANF

Households cannot claim real property outside Texas as a homestead. **Exception:** Migrants and itinerant workers who meet the residence requirements in A-710, General Policy, may claim an exemption for a homestead outside Texas.

SNAP

All homesteads and property are exempt.

A-1236.2.1 Homestead Temporarily Unoccupied

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

A homestead temporarily unoccupied because of employment, training for future employment, illness (including receiving medical treatment), casualty (fire, flood, state of disrepair, etc.), or natural disaster, if the household intends to return, is exempt.

A-1236.2.2 Sale of a Homestead

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Money remaining from the sale of a homestead is counted as a resource.

A-1236.3 Income-Producing Property

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Income-producing property is any real or personal property that generates income. Property is exempt if the property:

- is essential to a household member's employment or self-employment, such as tools of a trade, farm machinery, stock, and inventory (this property continues to be exempt during temporary periods of unemployment if the individual expects to return to work);
- annually produces income consistent with a fair market value comparable in the community, even if used only on a seasonal basis such as rental property (to determine that the income produced is comparable to the fair market value for similar usage of real property in the area, eligibility staff may contact local realtors, tax assessors, the Small Business Administration or similar sources); or
- is necessary for the maintenance or use of a vehicle exempted as income-producing or as necessary for transporting a household member with a physical disability. The portion of the property used for this purpose is exempt.

Note: For farmers or fishermen, the value of land or equipment continues to be exempt for one year from the date that the self-employment ceases.

A-1236.4 Real Property

Revision 19-4; Effective October 1, 2019

TANF, Children on TP 32 and Children on TP 56

Equity value of real property counts unless it is otherwise exempt.

Any portion of real property directly related to the maintenance or use of a vehicle is exempt if the vehicle is:

- necessary for self-employment; or
- to transport a household member with a physical disability.

The equity value of any remaining portion counts unless it is otherwise exempt.

SNAP

Real property is exempt.

A-1236.4.1 Exemption Based on Good Faith Effort to Sell

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Real property is exempt if the household is making a good faith effort to sell it.

A-1236.5 Jointly Owned Property

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Property jointly owned by the household applying and other individuals not applying for or receiving benefits is exempt if the:

- household provides proof they cannot sell or divide the property without consent of the other owners; and
- other owners will not sell or divide the property.

SNAP

Jointly owned property is exempt.

Related Policy

Solely Owned Vehicles, A-1238.1

A-1237 Trust Funds

Revision 24-2; Effective April 1, 2024

TANF, SNAP, Children on TP 32 and Children on TP 56

Trust funds are exempt if all the following conditions are met:

- The trust arrangement is unlikely to end during the certification period.
- No household member can revoke the trust agreement or change the name of the beneficiary during the certification period.
- The trustee of the fund is either a:
  - court, institution, corporation or organization not under the direction or ownership of a household member; or
  - court-appointed person who has court-imposed limitations placed on the use of the funds which meet the requirements of this section; and
- The trust investments do not directly involve or help any business or corporation under the control, direction or influence of a household member.
- Trusts established from the household's own funds are exempt if the trustee uses the funds only to:
  - make investments on behalf of the trust; or
  - pay the education or medical expenses of the beneficiary.

A-1238 Vehicles

Revision 24-2; Effective April 1, 2024

TANF, SNAP, Children on TP 32 and Children on TP 56

The total value of all licensed vehicles used for income-producing purposes is exempt. A vehicle is considered income-producing if:

- used as a taxi, a farm truck or fishing boat;
- used to make deliveries as part of the person's employment;
- used to make calls on people or customers;
- required by the terms of employment; or
- the vehicle produces income consistent with its fair market value.

A vehicle necessary to transport a household member with a physical disability on the Eligibility Determination Group (EDG) or a person with a physical disability living in the home is exempt even if the person is disqualified and regardless of the purpose of the trip. No more than one vehicle for each household member with a physical disability may be exempt. There is no requirement that the vehicle be used primarily for the person with a physical disability. The SNAP work-registration criteria should be used to determine physical disability for this exclusion.

Note: These exemptions remain in effect when the vehicle is temporarily not in use.

SNAP

The following vehicles are exempt even when the vehicle is temporarily not in use:

- vehicles necessary for long-distance travel for employment such as the vehicle of a traveling salesperson or of a migrant farm worker who is following the migrant stream which does not include daily commuting;
- vehicles used as the household's home; and
- vehicles necessary to carry fuel for heating or water when it is anticipated to be the primary source of fuel or water for the household during the certification period.

Examples of situations where a vehicle may be exempt because it is necessary to carry the household's primary source of water or fuel for heating include:

- homes which do not have any connected utilities; or
- homes connected to utilities, but the utilities cannot be used for some reason, such as a verifiable health risk exists if the household drinks the water or the utilities are disconnected because the household failed to pay its bills.

The vehicle exemption remains in effect until the above criteria no longer exist. The vehicle exemption also remains in effect for:

- any licensed vehicle with equity value $1,500 or less;
- one vehicle with a Fair Market Value (FMV) less than $8,700 for each adult household member, regardless of how the vehicle is used*; and
- any other licensed vehicle with an FMV less than $8,700 that a person under 18 drives to work, training, school or to seek employment.*

*This also applies to any person who is an ineligible alien or disqualified member of the SNAP household. The FMV of each vehicle over of $8,700 is counted as a resource.

For all other licensed and unlicensed vehicles, the FMV over $8,700 is counted as a resource.

Up to $22,500 of the FMV for the highest valued countable vehicle is exempt. The FMV over $22,500 is counted as a resource.

TANF, Children on TP 32 and Children on TP 56

Vehicles with an FMV of less than $4,650 are excluded, regardless of the number of vehicles owned by a TANF-certified or disqualified household member. The FMV over $4,650 counts toward the household's resource limit.

A-1238.1 Solely Owned Vehicles

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

A vehicle with a title registered solely in one person's name is considered an accessible resource for that person. This includes:

- vehicles involved in community property issues when one person's name is on the title; and
- a vehicle registered solely in the individual's name that the individual claims to have purchased for someone else.

Exceptions: The vehicle is inaccessible if the title holder verifies that:

- the vehicle was sold but the name on the title has not been transferred to the buyer (in this situation, the vehicle belongs to the buyer);

Note: Any payments made by the buyer to the individual or the individual's creditors (directly) count as self-employment income (see A-1323.4, Self-Employment).

- the vehicle was sold but the buyer has not transferred the title into the buyer's name;
- the vehicle was repossessed;
- the vehicle was stolen; or
- the title holder filed for bankruptcy (Title 7, 11 or 13), and the individual is not claiming the vehicle as exempt from the bankruptcy estate. **Note:** In most bankruptcy petitions, the court will allow each adult individual to keep one vehicle as exempt for the bankruptcy estate. This vehicle is a countable resource.

A vehicle is accessible to an individual even though the title is not in the individual's name if the individual:

- purchased or is purchasing the vehicle from the person who is the title holder; or
- is legally entitled to the vehicle through an inheritance or divorce settlement.

A-1238.2 Jointly Owned Vehicles

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Vehicles jointly owned with another person not applying for or receiving benefits are considered inaccessible if the other owner is not willing to sell the vehicle.

Exception: See A-1247, Resources of Stepparents.

A-1238.3 Vehicles Over 20 Years Old

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The value of a vehicle over 20 years old is exempt if the value is not available. If the applicant provides the value for a vehicle older than 20 years, the amount provided should be accepted. **Note:** A vehicle’s age during any month of that year should be considered.

A-1238.4 Leased Vehicles

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

A person leasing a vehicle is not generally considered the owner of the vehicle because the:

- vehicle does not have any equity value,
- person cannot sell the vehicle, and
- title remains in the leasing company's name.

A leased vehicle is exempt until the individual exercises the option to purchase the vehicle. Once the individual becomes the owner of the vehicle, the vehicle counts as a resource.

The individual is the owner of the vehicle if the title is in the individual's name, even if the individual and the dealer refer to the vehicle as leased, and the vehicle counts as a resource.

A-1238.5 How to Determine Fair Market Value of Vehicles

Revision 24-2; Effective April 1, 2024

TANF, SNAP, Children on TP 32 and Children on TP 56

Determine the FMV of licensed vehicles using the average wholesale value listed in the Vehicles Registered at Address report on the Data Broker Combined Report. After the vehicle value is verified, it does not have to be re-verified unless resources are close to the resource limit and a change in the vehicle value results in a change in eligibility status. **Note:** If the household claims the listed value does not apply because the vehicle is in less-than-average condition, the household must provide proof of the true value from a reliable source, such as a bank loan officer or a local licensed car dealer.

The basic value of a vehicle is not increased because of low mileage, optional equipment or special equipment for a person with a disability.

The household's estimate of the value of vehicles no longer listed in the Data Broker System should be accepted unless it is questionable and would affect the household's eligibility. In this case, the household must provide an appraisal from a licensed car dealer or other evidence of the vehicle's, such as a tax assessment or a newspaper advertisement indicating the sale value of similar vehicles.

Determine the value of new vehicles not listed on the Data Broker Combined Report by asking the household to provide an estimate of the average wholesale value from a new car dealer or bank loan officer. If this cannot be done, the person's estimate should be accepted unless it is questionable and would affect eligibility. The vehicle's loan value should be used only if other sources are unavailable. Household's must provide proof of the value of licensed antiques and custom made or classic vehicles if an accurate appraisal cannot be made.

Determining Vehicle Resource Values

Type of Vehicles	SNAP	TANF, Children on TP 32 and Children on TP 56
Income-producing	Exempt	Exempt
Vehicle for a person with a physical disability living in the home	Exempt	Exempt
Equity value less than or equal to $1,500	Exempt	Not applicable
Long distance travel for employment	Exempt	Exempt up to $4,650 of FMV. Count excess.
Household's home	Exempt	Exempt up to $4,650 of FMV. Count excess.
Carry fuel or water	Exempt	Exempt up to $4,650 of FMV. Count excess.
Primary vehicle or Highest valued countable vehicle	Exempt up to $22,500 of FMV. Count excess.	Exempt up to $4,650 of FMV. Count excess.
One vehicle for each adult household member, regardless of use	Exempt up to $8,700 of FMV. Count excess.	Exempt up to $4,650 of FMV. Count excess.
Any vehicle used by a household member under 18 for employment, training, education or to seek employment	Exempt up to $8,700 of FMV. Count excess.	Exempt up to $4,650 of FMV. Count excess.
Other licensed vehicles	Exempt up to $8,700 of FMV. Count excess.	Exempt up to $4,650 of FMV. Count excess.
Unlicensed vehicles	Exempt up to $8,700 of FMV. Count excess.	Exempt up to $4,650 of FMV. Count excess.

Related Policy

Vehicles, A-1238

A-1239 Educational Assistance

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Educational assistance (including education loans, regardless of the source) is exempt during the period it is intended to cover. If the individual combines the educational assistance with other countable funds, such as a bank account, the educational assistance is exempt during the period that it is intended to cover. For example, educational assistance intended for the months of January through May is an exempt resource during the same months.

Related Policy

Educational Assistance, A-1322.1

A-1240, Determining Countable Resources in Special Situations

Body

A–1241 Inaccessible Resources

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The equity value of resources that are not legally available (inaccessible) to the household are exempt.

Examples: Irrevocable trust funds, property in probate, security deposits on rental property and utilities, and the balance of a note from the sale of property.

Money received from a nonmember is inaccessible if:

- it is intended and used only for a nonmember's benefit, and
- the individual can provide verification of the intent and use of the money.

This includes any bank account that a household member has access to. A bank account is considered inaccessible if the money in the account is used solely for the nonmember's benefit.

The household must provide verification that the bank account is used solely for the nonmember's benefit and that no household members use the money in the account for their benefit. If household members use any of the money for their benefit, the bank account must be considered accessible to the household.

A temporarily inaccessible resource is exempt until the resource is accessible. Government savings bonds are an example of a temporarily inaccessible resource. These types of savings plans are usually inaccessible for a definite time from the date the individual makes a withdrawal request. The date the household applies is used as the date of the withdrawal request, unless the household has a withdrawal request pending at the time of application. For these pending withdrawals, the date of the actual withdrawal request is used to determine the length of time the resource is inaccessible.

Related Policy

Solely Owned Vehicles,A-1238.1
Jointly Owned Vehicles, A-1238.2
Bank Accounts, A-1231.1

A–1241.1 Nonliquid Resources

Revision 17-1; Effective January 1, 2017

SNAP

Nonliquid resources, except vehicles, are exempt. Vehicle policy in A-1238, Vehicles, applies.

TANF, Children on TP 32 and Children on TP 56

Count the equity value of nonliquid resources.

A–1242 Lump-Sum Payments

Revision 22-3; Effective July 1, 2022

TANF, SNAP, Children on TP 32 and Children on TP 56

Countable lump-sum payments include, but are not limited to, retroactive lump-sum RSDI, public assistance, retirement benefits, lump-sum insurance settlements, refunds of security deposits on rental property or utilities and lump-sum child support payments.

Lump-sum payments received once a year or less frequently are counted as resources in the month received, unless specifically excluded by other policies.

Lump-sum payments received or anticipated more often than once a year are counted as unearned income in the month received.

If a portion of a lump sum will be received as ongoing income, the ongoing portion is counted as income in the month received.

Example: A person receives a lump-sum payment in the amount of $4,950 from the Social Security Administration in the month of March. Effective that same month, the person receives their first monthly RSDI payment of $950, which is included in the $4,950 lump-sum payment. Budget the $950 RSDI payment beginning with the month of March as an ongoing payment and consider the $4,000 as a lump-sum payment.

Exceptions:

- Federal tax refunds and EITCs are exempt from resources for a period of 12 months after receipt.

- If a person is scheduled to receive retroactive SSI benefits in installment payments of up to three payments, paid every six months:
  - the payments count as a resource in the month received if the person is not a current SSI recipient; and
  - the payments are excluded if the person is a current SSI recipient.

Related Policy

Cash Gifts and Contributions, A-1326.1
Lump-Sum Payments, A-1331

TANF, Children on TP 32 and Children on TP 56

The One-Time Temporary Assistance for Needy Families (OTTANF) payment is exempt from resources for the month of receipt because the household is a TANF recipient that month. Any remaining OTTANF benefits are considered a resource the month after receipt.

A One-Time TANF for Relatives payment is a resource of the TANF-certified child or children and is exempt from resources.

Related Policy

When Receipt of TANF Is Uncertain, A-161
Resources of TANF and SSI Recipients, A-1248

A—1243 Payments Exempt as a Resource While Being Considered Income

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

If a payment or benefit counts as income for a particular month, it is not counted as a resource in the same month. If you prorate a payment as income over several months, no portion of the payment is considered a resource during that time.

Example: Income of students or self-employed persons that is prorated over several months.

If the individual combines this money with countable funds, such as a bank account, the prorated amounts are exempt for the time prorated.

A—1244 Reimbursements

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Reimbursements are counted as a resource in the month after receipt.

Reimbursements earmarked and used for replacing or repairing an exempt resource are exempt indefinitely.

Related Policy

Reimbursements, A-1332

A—1245 Resources of an Alien's Sponsor

Revision 19-1; Effective January 1, 2019

TANF, SNAP and Children on TP 56

Resources of an alien's sponsor and spouse (if the spouse also signed an affidavit of support) must be evaluated. The sponsor's countable resources must be determined when determining the applicant's resources. The total value of these resources must be reduced by $1,500. See the Glossary for the definition of an alien sponsor.

The remainder must be added to the alien's countable resources. If someone sponsors more than one alien, the amount of countable resources is prorated evenly among all the aliens who apply for or get benefits.

This policy does **not** apply to sponsored aliens who:

- are under age 18;

- are ineligible for benefits (examples include those who are disqualified from getting benefits or those considered non-members, such as students who do not meet SNAP student eligibility criteria);
- have become naturalized U.S. citizens;
- have worked or can receive credit for 40 quarters of work;
- have a deceased sponsor;
- have a sponsor who is a member of the alien's household or Modified Adjusted Gross Income (MAGI) household composition;
- are refugees, parolees, asylum grantees, Amerasians, victims of severe trafficking or Cuban or Haitian entrants;
- are battered alien spouses of U.S. citizens or of legal permanent residents, children of battered aliens, or parents of battered children, if
  - HHSC determines the battery is substantially related to the need for benefits; and
  - the battered person does not live with the batterer; or
- are indigent.

Notes:

- The criterion for indigent aliens applies only if the alien does not meet one of the other exceptions noted in this list. Only the amount the sponsor will give the alien for a 12-month period starting the date HHSC makes the indigence determination should be deemed. Each determination is renewable for additional 12-month periods.
  - Each time a determination of indigence is made, a memo must be sent with the name, address, Social Security number and date of birth, of both the indigent alien and the indigent alien's sponsor, to Texas Works Policy Section, 909 W. 45th St., Bldg. 2, Mail Code 2115, Austin , TX 78751.
  - Before sending the memo, explain to the sponsored alien that regulations require the state to report the sponsor to the United States Citizenship and Immigration Services (USCIS) for failure to give support as required on the sponsor affidavit.
  - The alien may choose to have the sponsor's resources deemed if the alien does not want the state office to send this report.
- The sponsor's resources must not be deemed for 12 months for battered aliens, starting the month the alien is certified for any benefit. A new 12-month period must not be assigned if the alien reapplies after denial of benefits. After the first 12 months, the sponsor's resources continue to be exempt from deeming if:
  - a court or the U.S. Citizenship and Immigration Services recognize the battery;
  - HHSC determines the battery has a substantial connection to the need for benefits; and
  - the alien does not live with the batterer.
- The following list of circumstances may be used as a guide in making the substantial connection between the battery and the need for benefits. Staff may determine whether the battered alien needs the benefits:
  - to become self-sufficient after leaving the abuser;
  - to escape the abuser, the community where the abuser lives, or both;
  - to ensure the battered alien's safety;
  - to replace financial support lost as a result of the separation from the abuser;
  - because of the loss of a job or reduced earnings resulting from the battery or cruelty;
  - because the battered alien needs medical attention or mental health counseling or now has a disability due to the battery;
  - because the battered alien lost the home, and the separation from the abuser jeopardizes the battered alien's ability to care for the children;
  - to reduce nutritional risks;
  - to get medical care for a pregnancy resulting from sexual assault or abuse; or
  - to replace medical coverage or health care services.

TANF and Children on TP 56

This policy does not apply to:

- sponsored aliens whose sponsors get TANF or SSI; or
- the dependent child of a sponsor or sponsor's spouse.

SNAP

This policy does not apply to:

- sponsored aliens whose sponsors get SNAP as a member of the same household; or
- organizations or groups that sponsor aliens.

A–1246 Resources of Residents in Shelters for Battered Persons

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Resources of residents in shelters for battered persons are exempt if:

the resources are jointly owned by the household in the shelter and members of the former household; and

the shelter resident's access to the value of the resource depends on the agreement of a joint owner who still lives in the resident's former household.

A—1247 Resources of Stepparents

Revision 15-4; Effective October 1, 2015

TANF

All resources of a stepparent must be counted if the stepparent is included in the certified group. When the stepparent is not included in the certified group, only the legal parent's half of a jointly owned resource should be counted.

Children on TP 32 and Children on TP 56

When a stepparent is included in the child's household composition, all resources of a stepparent are counted.

Related Policy

Earnings of a New TANF Spouse, A-1249.2

A—1248 Resources of TANF and SSI Recipients

Revision 22-1; Effective January 1, 2022

TANF, Children on TP 32 and Children on TP 56

The resources of an SSI recipient living in the home, even when the resources are available to the TANF-certified member or Medical Programs household member, are exempt if:

- the SSI recipient would otherwise be a certified member in the TANF or Medical Programs EDG;
- the SSI recipient would otherwise be someone whose income is:
  - applied to the TANF budget; or
  - included in the Medical Programs household composition; or
- a TANF-certified or disqualified person or member of the Medical Programs household composition is the SSI recipient's payee.

This policy applies to:

- people who continue to receive SSI Medicaid when their SSI financial assistance is denied because of earnings; and
- children who receive SSI Medicaid that the person chooses not to include in the TANF-certified group.

If other SSI recipients live in the home and contribute to a member of the TANF-certified group, disqualified group or Medical Programs household composition, follow policy for cash gifts and contributions.

SNAP

Exempt the resources of TANF and SSI recipients unless the recipient owns them with another member of the same SNAP household and that other member does not receive TANF or SSI.

Note: Consider a household member a TANF or SSI recipient, even if the benefit:

- has not yet been received;
- is suspended; or
- is being recouped.

When a TANF or SSI recipient owns a resource with a member of the same SNAP household who does not receive TANF or SSI, determine countable resources as follows:

- **Nonliquid resources** — Exempt the TANF or SSI recipient's portion of a nonliquid resource if the recipient jointly owns it with another member of the SNAP household.
- **Liquid resources** — Exempt or count liquid resources according to the following guidelines:
  - Commingled resources — Exempt the TANF or SSI recipient's portion of commingled resources for six months from the month the person combined them. After six months, count the total amount of commingled resources as an available resource to the non-TANF or SSI recipient if it remains accessible.
  - Jointly owned resources (not commingled) — Exempt these resources if all the contributed money is from a TANF or SSI recipient and the resource is solely for:
    - expenses of the TANF or SSI recipient; or

- common household expenses.

Related Policy

Cash Gifts and Contributions, A-1326.1

A—1249 Resources Resulting from Earnings

Revision 04-1; Effective January 1, 2004

A—1249.1 Earnings of a Child

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Staff must exempt any liquid resources resulting from the earnings of a child (certified child for TANF or eligible child for Medical Programs) who is attending school:

- full time, or
- less than full time and employed less than 30 hours a week.

Note: A child who is home schooled or attends general equivalency diploma (GED) classes is eligible for the resource exclusion.

Resources of a child that are commingled with resources of other household or non-household members are excluded. The child's liquid resources are exempt for six months from the month the resources were combined. After six months, the amounts previously earned as a resource are counted.

A—1249.2 Earnings of a New TANF Spouse

Revision 15-4; Effective October 1, 2015

TANF

The liquid resources of a TANF recipient's new spouse are excluded for six months beginning the month after the date of the marriage if the:

- resource results from the new spouse's earnings, and
- total gross income of the budget group does not exceed 200 percent FPIL for the family size.

Note: This applies to both ceremonial and common law marriages. The following are included in the budget group:

- the caretaker or payee of the TANF-certified group;
- the new spouse of the TANF caretaker or payee;
- each dependent of the TANF caretaker or payee and the new spouse who meets the TANF age and relationship requirements and lives in the household; and
- anyone who would be a required member if not disqualified or ineligible such as an SSI recipient or ineligible alien.

If the household fails to provide verification of the marriage, the exclusion is not allowed. After six months, the amount previously earned is counted as a resource.

A-1250, Verification Requirements

Body

Revision 16-2; Effective April 1, 2016

TANF, SNAP, Children on TP 32 and Children on TP 56

Staff must verify:

- resources if:
  - they are questionable,
  - the value is within $300 of the maximum allowable limit, or
  - it is a regional requirement.
- all checking or savings accounts at application or when a household reports a new account (except SNAP, see below).

- that inaccessible resources, including bank accounts:
  - are used solely for the non-member's benefit, and
  - that no household members use the money for their benefit.
- a person’s statement about the inaccessibility of a vehicle if it is within $300 of the resource limit.
- the fair market value of licensed vehicles as explained in A-1238.5, How to Determine Fair Market Value of Vehicles.
- an exempt trust fund that meets conditions in A-1237, Trust Funds.
- the exempt or countable status of an education and/or retirement plan or account at application or when a household reports a new account.
- the death of an alien's sponsor (does not apply to children on TP 32).

TANF, Children on TP 32 and Children on TP 56

Staff must verify a good faith effort to sell by verifying that the:

- property is for sale, and
- household has not refused a reasonable offer.

SNAP

Staff must verify:

- the equity value of a licensed vehicle if exempting the vehicle because the equity value is less than or equal to $1,500.
- a bank account if verification can be obtained during the interview. If verification cannot be obtained during the interview, the person’s statement may be accepted without verification if:
  - the person states that the household's total combined balance for all accounts does not exceed $1,000; and
  - the person’s statement is not questionable.

The EDG is pended only if the reported account balance exceeds $1,000 or the person’s statement is questionable.

TANF

Staff must verify:

- the date of marriage between a TANF recipient and new spouse. The date of marriage is used to determine the six-month period in which the new spouse's earnings can be excluded as a resource.
- the amount of liquid resources resulting from the earnings of a new TANF spouse.

A-1251 Verification Sources

Revision 21-1; Effective January 1, 2021

TANF, SNAP, Children on TP 32 and Children on TP 56

Vehicles

- Data Broker System;
- statements from:
  - finance company or bank;
  - insurance agent;
  - car dealers; or
  - Texas Department of Motor Vehicles (DMV);
- city or county government records; or
- newspapers.

Real Property

- statements from:
  - tax appraisal or collector office;
  - county courthouse official;
  - real estate company;
  - bank or financial institution;
  - local land owners (nonrelative); or
  - county agent.

Alien Sponsor's Death

The Texas Bureau of Vital Statistics (BVS), if available, is considered the primary source of verification of death. If BVS is available but the date of death (DOD) does not match reported information, accept BVS as verification. No additional verification is required.

If BVS verification is not available, verify the DOD using two of the following sources:

- Social Security Administration (SSA);
- statement from guardian or authorized representative;
- copy of death certificate;
- statement from a doctor;
- newspaper death notice (obituary);
- statement from a relative or household member;
- statement from funeral director; or
- records from the hospital or other institution where the person died.

TANF, SNAP, Children on TP 32 and Children on TP 56

Bank Account

- current bank statements (within last three months), or
- statement from bank official.

Debit Account

- Electronic Benefit Transfer (EBT) cash accounts via the:
  - EBT System; or
  - Lone Star Help Desk automated voice response system at 800-777-7328, if staff have the cardholder's 19-digit personal account number (PAN);
- Unemployment Insurance Benefit (UIB) debit accounts via:
  - online at usbankreliacard.com; or
  - any bank ATM;
- Texas Office of Attorney General (OAG) child support debit accounts online at EPPICard.com; or
- Social Security Direct Express card (RSDI or SSI) debit accounts via:
  - online at USDirectExpress.com;
  - calling the Direct Express card help desk automated voice response system at 888-741-1115, if the advisor has the cardholder's 16-digit card number; or
  - current receipt (free of charge) from any ATM that displays the MasterCard® logo.

Other Liquid Assets/Personal Property

- recent sales slips;
- insurance or tax appraisals;
- catalogs or newspaper;
- statements from:
  - experts or other collectors;
  - bank;
  - brokers; or
  - local merchants;
- retirement benefit letters; or
- education plan or account benefits summary letters.

Life Insurance

- Insurance policy; or
- Statements from:
  - Insurance company;
  - Insurance agent; or
  - Union, employer, funeral director, organization or agency that provides insurance.

Nonrecurring Lump-sum Payments

- statements from the company, agency or organization that provided payment;
- checks, award letters or check stubs; or
- bank statements or deposit slips.

TANF

Ceremonial Marriage

- marriage license or certificate;
- church records;
- statement from clergy; or
- family Bible records.

Common Law Marriage

- Declaration of Informal Marriage filed with the county clerk;
- sworn statement signed by both spouses; or
- Form H1057, Declaration of Informal Marriage.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A-1260, Documentation Requirements

Body

Revision 21-2; Effective April 1, 2021

TANF, SNAP, Children on TP 32 and Children on TP 56

Documentation is required for the following:

- to indicate whether a resource is countable or exempt and explain if it is questionable;
  Note: For SNAP, this requirement applies only to vehicles and liquid resources.
- calculations used to determine the equity value for resources with allowable deductions;
- the total value of countable resources;
- the dates and amounts of any resources received while the EDG is active;
- the facts surrounding a transfer of resources;
- how resources were verified and the date of verification;
- that information was provided to a sponsored alien who meets the indigent criteria about the requirement to report the alien's sponsor to USCIS for failure to give support and if the alien chose to have the sponsor's resources deemed instead;
  Note: Does not apply to children on TP 32.
- the type of any retirement account, plan, or education tuition savings plan, or any combination, and the Internal Revenue Code provision under which the plan was established; and
- the source used to verify the death of an alien's sponsor.

TANF, Children on TP 32 and Children on TP 56

Document the good faith effort to sell real property and the:

- reason for exempting the property; and
- household's efforts to sell it.

TANF

Documentation is required for the following:

- the months of the six-month period that the earnings of a new spouse of a TANF recipient will be excluded as a liquid resource;
- the amount of the earnings of the new spouse of a TANF recipient that will be excluded as a liquid resource; and
- the reason for not pursuing a legally entitled resource per policy.

TANF and SNAP

Document the facts about a transfer of resources per policy.

Related Policy

Requirement to Pursue Resources, A-1211
Transferring Resources, A-1212
Documentation, C-940
The Texas Works Documentation Guide

A-1300, Income

A-1310, General Policy

Body

Revision 21-2; Effective April 1, 2021

All Programs

Income is any type of payment that is of gain or benefit to a household and is either counted or exempted from the budgeting process. Earned income is related to employment. Except for MAGI medical programs, earned income entitles a household to deductions not allowed for unearned income. Unearned income is income received without performing work-related activities and includes benefits from other programs. Factors specific to the source of income and the distance it travels through the mail (weekends and holidays) may be used to determine the date income can reasonably be anticipated.

TANF and SNAP

Retirement, Survivors, and Disability Income (RSDI), Supplemental Security Income (SSI), Veterans Affairs (VA) benefits, or other such funds legally obligated to a beneficiary are not counted if a payee who is not a member of the household:

- receives the funds; and
- does not make the money available to the beneficiary.

In the beneficiary's Eligibility Determination Group (EDG), the total amount of the legally obligated funds the payee makes available to the beneficiary in cash, by way of vendor payment or through items purchased for the beneficiary using the beneficiary's money (includes payments made by the payee to a third party on behalf of the beneficiary) is counted as unearned income. Any portion of the funds the payee keeps for the payee's own use is counted as unearned income in the payee's EDG.

TANF

The income of the following people must be considered for Temporary Assistance for Needy Families (TANF):

- any person in the certified or budget group, or EDG member, including disqualified members;
- any person living in the home who is not included in the certified or budget group but who is legally responsible for a member of the certified group; and
- an alien's sponsor.

For TANF, if the income is not made available to the beneficiary, the person must follow the requirements for pursuing legally obligated income.

SNAP

The income of the following people must be considered for the Supplemental Nutrition Assistance Program (SNAP):

- any member of the SNAP household, including disqualified members; and
- an alien's sponsor.

Medical Programs

Modified Adjusted Gross Income (MAGI) rules are based on Internal Revenue Service (IRS) rules for counting income and are used to determine financial eligibility for medical programs and federal insurance affordability programs.

To determine financial eligibility, the following items must be identified for each person within the MAGI household composition:

- earned income, excluding any pre-tax contributions;
- unearned income;
- self-employment income;
- American Indian (AI)/Alaska Native (AN) disbursements;
- overpayments; and
- expenses.

The income of the following people must be considered for medical programs:

- any person who is included in the person's MAGI household composition; and
- an alien's sponsor (if applicable).

Note: Household composition for medical programs is determined for each applicant or recipient. The income of certain people may be exempt from an applicant's or recipient's MAGI household income as explained in A-1341, Income Limits and Eligibility Tests, Medical Programs, Step 3.

TP 40

If a pregnant woman is determined to be eligible, the EDG must not be denied if the pregnant woman's MAGI household composition income increases above the income limit. The budget should be adjusted to reflect the new income.

TP 45

Income is not an eligibility factor for TP 45.

Related Policy

Requirement to Pursue Income, A-1311
Income Limits and Eligibility Tests, A-1341
Alien Sponsor's Income, A-1361
Eligibility Criteria, B-471
Special Provisions for Households with Elderly Members or Members with a Disability, B-433
Categorically Eligible Households, B-470

A-1311 Requirement to Pursue Income

Revision 25-4; Effective Oct. 1, 2025

TANF

People applying for or receiving benefits must pursue and accept all legally entitled income. Inform them about this requirement and develop a plan to pursue the potential income. Allow at least three months, to pursue the income and do not consider the income available during this time. Discuss with the person about their obligation to pursue potential income and include the allowable time to pursue the income in the comments section of Form TF0001, Notice of Case Action.

Exception: The person does not have to pursue income if it would be unreasonable. Consider a situation unreasonable if:

- the cost to pursue the income exceeds the potential income or causes financial hardship;
- pursuing the income would endanger the person's health or safety; or
- legal action is required, but a private attorney or legal services refuses to accept the case. The person must make a reasonable effort to find and request legal assistance.

Document the plan and the time allowed to pursue income. If the household refuses or fails to follow the agreed plan without good cause, deny the EDG.

Set a special review if the anticipated change in income occurs before the next periodic redetermination.

Related Policy

Documentation Requirements, A-1380

A-1311.1 Requirement to Pursue SSI or RSDI

Revision 23-2; Effective April 1, 2023

TANF

Staff must provide and explain the doument, Social Security Administration Benefits for People with Disabilities Receiving TANF (English PDF or Spanish PDF), to households claiming a disability or caring for a child with disabilities. Staff must also document that it was provided and explained to the recipient.

Staff are not required to set a special review when referring recipients for Social Security benefits. At the next periodic redetermination, the household must provide verification that the recipient with disabilities applied for SSI or RSDI benefits.

In the comments section of Form TF0001, Notice of Case Action, staff must inform recipients of their obligation to pursue potential income and include the time allowed for pursuing income. Staff must include the following appropriate statement for households claiming a disability or caring for a child with disabilities:

- English – "You must apply for assistance with the Social Security Administration and provide proof of the application at your next TANF interview."
- Spanish – "Tiene que solicitar asistencia de la Administración del Seguro Social y presentar prueba de la solicitud en su próxima entrevista de TANF."

Deny the EDG if the household fails to apply for SSI or RSDI, without good cause. If the household chooses to no longer claim the Choices exemption, staff should update the exemption code and document the decision. The recipient may not claim the Choices exemption if the person reapplies within 12 months from the denial date. If the person claims the exemption before the 12 months, pend the EDG and give the person the opportunity to provide verification that they applied for SSI or RSDI benefits.

A-1311.1.1 SSI/RSDI Application Assistance

Revision 15-4; Effective Oct. 1, 2015

TANF

State office has an automated process that identifies TANF recipients with a Choices exemption for caring for a child with disabilities and unable to work due to mental or physical disability and sends referrals to the contractor who administers the Social Security Outreach Application Program (SSOAP). SSOAP outreaches the TANF household, provides information, and answers questions about the Social Security Administration (SSA) process.

If an individual states that the household applied for SSI/RSDI, but does not have verification available, the advisor should refer to the Wire Third-Party Query (WTPY)/State Online Query (SOLQ) system. If the WTPY/SOLQ system does not show that the individual applied for benefits, the advisor should request that the individual provide verification.

The EDG should not be denied if:

- the individual is physically or mentally unable to complete the SSI/RSDI application process; and
- SSOAP and SSA fail or are unable to provide assistance needed to complete the SSI/RSDI application process.

A-1311.1.2 Social Security Administration (SSA) Definitions and Guidelines

Revision 25-4; Effective Oct. 1, 2025

TANF

The SSA administers two programs that provide benefits based on disability:

- RSDI provides disability benefits to people and their dependents with disabilities under certain conditions.
- SSI provides benefits to people with disabilities, including children under 18, who have limited income and resources.

The Social Security Act and SSA's regulations define disability:

- For all people applying for RSDI and adults applying for SSI, the definition of disability is the same. The law defines disability as the inability to engage in substantial gainful activity because of physical or mental impairments which may result in death or has lasted or is expected to last for a continuous period of not less than 12 months.
- For children under 18 years applying for SSI, the law defines disability as a physical or mental impairments that results in marked and severe functional limitations and may result in death or has lasted or is expected to last for a continuous period of not less than 12 months.

Refer the person to apply for SSI if they meet one of the following conditions:

- Psychological or psychiatric problems:
  - actual clinical diagnosis or medical documentation that shows the person cannot work;
  - odd or inappropriate behavior; or
  - inability of a long-time TANF person to get or keep a job for more than 30 days because of a mental impairment.
- Obesity combined with any other physical problems such as arthritis, high blood pressure, heart failure, respiratory disease or vascular disease.
- Low intelligence:
  - former special education student;
  - inability to read or write even though the person went to school;
  - basis test scores below 200
  - failure to understand even the simplest directions; or
  - down syndrome.
- Serious substance abuse when combined with other related health problems.
- Serious health problems:
  - multiple sclerosis, cancer, stroke, multiple surgeries for the same problem, multiple trauma and other situations;

    - chronic health problems; or
    - Newborns with low birth weight of 1200 grams or less within the first few days after birth.
- Over 50 with health problems, especially if combined with limited education and limited work history.

Note: A person, including a child, applying for SSI based on disability or blindness may receive up to six months of payments before the final determination of disability or blindness if the claimant is determined to presumptively have a disability or be blind and meets all other eligibility requirements.

Related Policy

Definition of Disability, B-432
Social Security's Criteria for Disability, B-432.1

A-1320 Types of Income

Revision 15-4; Effective Oct. 1, 2015

All Programs

There are differences between TANF, Medical Programs and SNAP in countable and exempt income.

TANF and SNAP

Income that is not specifically listed in this section must be counted.

A-1321 Disability Benefits

Revision 13-2; Effective April 1, 2013

A-1321.1 Agent Orange Settlement Payments

Revision 15-4; Effective Oct. 1, 2015

All Programs

Agent Orange Settlement Payments disbursed by AETNA Insurance Company and paid to the following individuals are exempt:

- veterans with disabilities exposed to Agent Orange while in Vietnam who suffer from total disabilities caused by any disease, and
- survivors of these deceased veterans.

These veterans receive yearly payments. Survivors of these deceased veterans receive a lump-sum settlement payment.

TANF and SNAP

VA payments are counted as unearned income, including benefits paid to veterans with service-connected disabilities resulting from exposure to Agent Orange. See A-1324.20, Veterans Benefits.

Related Policy

Lump-Sum Payments, A-1331

A-1320, Types of Income

Body

Revision 15-4; Effective October 1, 2015

All Programs

There are differences between TANF, Medical Programs and SNAP in countable and exempt income.

TANF and SNAP

Income that is not specifically listed in this section must be counted.

Revision 13-2; Effective April 1, 2013

A-1321.1 Agent Orange Settlement Payments

Revision 15-4; Effective October 1, 2015

All Programs

Agent Orange Settlement Payments disbursed by AETNA Insurance Company and paid to the following individuals are exempt:

- veterans with disabilities exposed to Agent Orange while in Vietnam who suffer from total disabilities caused by any disease, and
- survivors of these deceased veterans.

These veterans receive yearly payments. Survivors of these deceased veterans receive a lump-sum settlement payment.

TANF and SNAP

VA payments are counted as unearned income, including benefits paid to veterans with service-connected disabilities resulting from exposure to Agent Orange. See A-1324.20, Veterans Benefits.

Related Policy

Lump-Sum Payments, A-1331

A-1321.2 Disability Insurance Benefits

Revision 16-4; Effective October 1, 2016

All Programs

Disability insurance benefits are normally paid to an individual who has suffered injury or impairment. These payments may be from an employer, insurance provider, or other public or private fund.
Advisors must determine the source of the benefit.

- If the source is covered by an income type listed in A-1320, Income Types, such as RSDI [see A-1324.16, Retirement, Survivors and Disability Insurance (RSDI)], the procedures for that benefit must be used.
- If the source is not covered by another income type listed in A-1320, the policy listed below must be used.

TANF and SNAP

Count as unearned income.

Medical Programs

Disability insurance benefits are exempt.

A-1321.3 Radiation Exposure Compensation Act Payments

Revision 15-4; Effective October 1, 2015

All Programs

Payments from the Radiation Exposure Compensation Act (the “Act”), Public Law 101-426, are exempt.

The Act established a program to pay damages to individuals for injuries or deaths caused by exposure to radiation from nuclear testing and uranium mining. When the affected individual is deceased, the surviving spouse, children, parents, grandchildren, or grandparents receive the payments.

A-1321.4 Worker's Compensation

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The gross benefit is counted as unearned income, less amounts:

- recouped for a prior worker's compensation overpayment; or
- paid for attorney's fees. **Note:** The Texas Workers' Compensation Commission (TWCC) or a court sets the amount of the attorney's fee to be paid.

A deduction from the gross benefit for court-ordered child support payments is not allowed.

Exception: Worker's compensation benefits paid to the individual for out-of-pocket medical expenses are considered as reimbursements.

Medical Programs

All workers' compensation payments are exempt.

A-1322 Education and Training

Revision 13-2; Effective April 1, 2013

A-1322.1 Educational Assistance

Revision 15-4; Effective October 1, 2015

All Programs

Educational assistance, including educational loans, scholarships, fellowships, grant monies, and work study, are exempt, regardless of the source. Loans for education, including loans from relatives or other people, are considered as educational assistance only if payment is deferred.

Educational assistance is:

- any financial aid for vocational or educational courses from:
  - an organization (such as fraternal, alumni, etc.); or
  - a government program or agency (such as the U.S. Office of Education or Department of Veterans Affairs).
- provided to students who are enrolled in a:
  - program that provides for completion of a secondary high school diploma or the equivalent (such as a general equivalency diploma [GED]);
  - school for people with intellectual or physical disabilities; or
  - post-secondary institution.

Note: "Post-secondary" includes institutions of higher education and others not requiring a high school diploma (such as community colleges and vocational educational programs) authorized by the state to provide educational or training programs beyond secondary education.

The U.S. Office of Education under Title IV of the Higher Education Act administers most educational assistance programs. A few examples of the most common Title IV educational assistance grants include:

- Pell Grants,
- Stafford Loan Program,
- Parent Loans for Students (PLUS Loans),
- Supplemental Educational Opportunity Grants,
- College Work Study, and
- Carl D. Perkins Loans (Title IV, Part E) (formerly National Direct Student Loans).

The National Community Services Act (NCSA) program also provides educational assistance. Individuals are awarded from $1,000 to $4,000 per year of completed services to apply toward past or future educational expenses. The educational award is not counted, as it is always made payable directly to the financial institution or institution of higher learning.

The Department of Veterans Affairs administers education programs designed for veterans, reservists, members of the National Guard, and their widows and orphans. These include:

- Montgomery GI Bill (MGIB) Active Duty Educational Assistance Program,
- Vocational Rehabilitation,
- Post-Vietnam Era Veterans' Educational Assistance Program (VEAP),
- Survivor's and Dependent's Educational Assistance (DEA), and
- MGIB - Selected Reserve Educational Assistance Program.

Related Policy

Educational Assistance, A-1239

A-1322.2 Job Training

Revision 03-7; Effective October 1, 2003

A-1322.2.1 Workforce Innovation and Opportunity Act (WIOA)

Revision 15-4; Effective October 1, 2015

All Programs

Temporary employment of six months or less for disaster-related work, paid under the Workforce Innovation and Opportunity Act and funded by the National Emergency Grant, is exempt.

TANF and Medical Programs

All WIOA payments are exempt.

SNAP

All WIOA payments are exempt except on-the-job training (OJT) payments funded under the Workforce Innovation and Opportunity Act. OJT payments are counted as earned income for adults.

OJT payments are exempt if received by a child who is under:

- age 19, and
- under parental control of another household member.

Related Policy

Government Disaster Payments, A-1324.3

A-1322.2.2 Other Job Training and Training Allowances

Revision 15-4; Effective October 1, 2015

All Programs

Portions of payments earmarked as reimbursements for training-related expenses are exempt, and any excess is counted as earned income.

A-1323 Employment and Self-Employment Income

Revision 13-2; Effective April 1, 2013

A-1323.1 Children's Earned Income

Revision 26-3; Effective July 1, 2026

TANF

Follow policy for who is included in a TANF household. Count a dependent child 's earned income unless the child attends school:

- full-time, including a home-schooled child; or
- part-time enrolled and employed less than 30 hours a week.

Exception: Refer to related policy about the Workforce Innovation and Opportunity Act (WIOA).

SNAP

Count a dependent child's earned income unless the child:

- is under 18;
- attends elementary, middle or high school, including home schooling and general equivalency diploma (GED) classes; and
- lives with a natural or adoptive parent, a stepparent or other household member with parental control in the SNAP household.

Exception: Refer to related policy about the WIOA.

Related Policy

Who Is Included, A-221
Workforce Innovation and Opportunity Act (WIOA), A-1322.2.1
Verification Sources, A-1641

TANF and SNAP

Breaks in school attendance, such as summer vacation and holidays, do not change the student status of a child. Verify the child's enrollment will continue following the break.

Divide the total earnings equally by the number of working members if the child's earnings cannot be separated from other household members' earnings.

Medical Programs

Use the exceptions for counting a child's income in the MAGI household income. Refer to related policy for Medical Programs, **Step 3**.

Related Policy

Income Limits and Eligibility Tests, A-1341

A-1323.2 Contractual Earnings

Revision 05-5; Effective October 1, 2005

All Programs

Contractual earnings are wages and salaries only. Self-employment income, unearned income, or income received on an hourly or piecework basis are not included. The two basic types of contractual earnings are:

- Seasonal employment — available only during certain months of the year and recurs each year. Examples: school-related employment, certain types of farm work, and summer or winter employment. Divide seasonal employment that is a household's annual means of support over 12 months. If the income supports the household for only a portion of the year and the household has income from other sources the rest of the year, average the earnings over the time they are intended to cover.
- Contractual employment — nonseasonal employment that is contracted for a specific time and does not recur. Divide earnings over the time covered by the contract.

A-1323.2.1 Monthly Budgeting of Contractual Earnings

Revision 20-2; Effective April 1, 2020

All Programs

Budget contractual earnings monthly by:

- dividing the total gross amount earned under the contract by the number of months the contract covers or by 12 months, whichever is applicable; and
- adding this amount to any other income, and budgeting according to usual procedures.

Note: If the person does not receive the income agreed to in the contract, or if income is interrupted because of participation as a striker in a work slow-down or stoppage, do not budget the contractual earnings using the steps above since the person cannot reasonably anticipate receiving the contractual income. For strikers, follow policy in A-1367.1 . If the person's employment situation changes and contractual earnings resume:

- recalculate the income or adjust the benefits accordingly; and
- document all the facts that caused the recalculation or adjustment.

Related Policy

How to Project Income, A-1355
Strikers, A-1367
Eligibility of Strikers, A-1367.1

A-1323.3 Military Pay Allotments and Allowances

Revision 15-4; Effective October 1, 2015

All Programs

Military pay and allowances for housing, food, base pay, and flight pay is counted as earned income less pay withheld to fund education under the G.I. Bill.

An allotment is a specified amount of money from each paycheck of the military wage earner that is designated to go to someone else. Military allotments are counted as unearned income.

A-1323.3.1 Family Subsistence Supplemental Allowance (FSSA)

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The Family Subsistence Supplemental Allowance is a monthly payment made to certain low-income service members and their families so they will not have to depend on SNAP to meet their needs. The service members' pay statements usually include the FSSA and are counted as earned income.

Medical Programs

FSSA payments are exempt.

A-1323.3.2 Combat (Hazardous Duty) Payments

Revision 15-4; Effective October 1, 2015

TANF

All of the combat payments, also known as hazardous duty payments, received by a legal parent who is a member of the U.S. military, absent solely because the individual has been deployed to a combat zone, are counted.

SNAP

Any portion of military pay identified as combat pay, including any portion of combat pay contributed to a household from military personnel deployed to a combat zone, is excluded.

The advisor must determine whether any funds contributed to the household by military personnel, such as through joint bank accounts or military allotments, are considered combat pay. Any portion identified as combat pay is exempt from income. The following steps should be used to determine the amount of military income to exclude as combat pay:

Steps	Action
1.	Verify the monthly amount of combat pay received, as required in A-1370, Verification Requirements.
2.	Determine the amount of military pay the deployed individual was making available to the household **before** deployment to the combat zone. If the deployed person was: • a household member before deployment, the amount would be the individual's net military pay. • **not** part of the household before deployment, then consider any amount made available from the individual's pay before deployment.
3.	Determine the amount of military pay the deployed individual is making available to the household **after** deployment to the combat zone.

Steps	Action
4.	If the amount of contribution the household receives from the military personnel after deployment: • is equal to or less than the amount the household was receiving before deployment, then none of that contribution would be considered combat pay. Count the full amount of the contribution as unearned income. • exceeds the amount received before deployment, exclude the excess as combat pay (not to exceed the verified monthly amount of combat pay) and count the remainder (if any) as unearned income.

Medical Programs

Combat (hazardous duty) payments are exempt.

Related Policy

Who Is Included, A-241.1
Verification Requirements, A-1370
Glossary, Combat Pay and Combat Zone

A-1323.4 Self-Employment

Revision 12-4; Effective October 1, 2012

All Programs

Self-employment income is usually income from one's own business, trade, or profession rather than from an employer. However, some individuals may have an employer and receive a regular salary. If an employer **does not** withhold income taxes or FICA, even if required to do so by law, the person is considered self-employed.

Advisors must inform households in writing to keep self-employment records and receipts for verification purposes for future recertifications. Form TF0001, Notice of Case Action, contains the self-employment information.

Note: If a household has self-employment income and meets the streamlined reporting criteria, assign a six-month certification period.

A-1323.4.1 Types of Self-Employment Income

Revision 15-4; Effective October 1, 2015

All Programs

Types of self-employment include:

- odd jobs, such as mowing lawns, babysitting, and cleaning houses;
- owning a private business, such as a beauty salon or auto mechanic shop;
- farm income;
- income from property; and
- independent contracting.

A-1323.4.2 Property Income

Revision 15-4; Effective October 1, 2015

All Programs

Income from renting, leasing, or selling property on an installment plan is self-employment income. Property includes equipment, vehicles, and real property.

TANF and SNAP

Income from property is counted as:

- earned if the:
  - person spends an average of at least 20 hours a week in management or maintenance activities; or
  - income is from noncommercial boarding situations.

- unearned if the person spends an average of less than 20 hours a week in management or maintenance activities.

Work-related expenses are allowed for earned income. For unearned income, only the expenses associated with producing the income should be deducted.

If the individual sells property on an installment plan, the payments are counted as income. The balance of the note is exempted as an inaccessible resource.

Medical Programs

Income from renting, leasing, or selling property on an installment plan is counted as self-employment income.

A-1323.4.3 Noncommercial Roomer/Boarder Payments

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The noncommercial roomer/boarder policy is used if a noncertified household member makes payments to a certified member under a formal or informal landlord/tenant relationship. Payments made by boarders for room, meals, and other shelter expenses are counted. Payments made by roomers for room and other shelter expenses are counted.

See A-1323.4.5, Allowable Costs of Producing Income, to determine the countable amount of noncommercial roomer/boarder payments. If there is not a formal or informal landlord/tenant relationship, the policy in A-1326.1, Cash Gifts and Contributions, applies.

TANF

Roomer/boarder status should not be given to:

- anyone whose income can be applied to the certified group; or
- a dependent child who is an ineligible alien.

SNAP

To be considered a boarder, a person residing with the household must pay reasonable compensation for meals and lodging. Reasonable compensation is:

- the amount of the full allotment for the number of boarders if the boarders eat an average of more than two meals a day with the household; or
- two-thirds of the full allotment for the number of boarders if the boarders eat an average of two meals a day or less with the household.

In determining "reasonable compensation," only the amount paid for meals is counted if it can be separated from lodging.

If the individual chooses to include a boarder as a household member:

- all of the boarder's income, resources and deductions are counted; but
- the payment from the boarder is not counted as income since it is transferred between household members.

If the individual chooses not to include a boarder as a household member:

- the boarder's income, resources, or deductions are not included in the household; but
- the payment from the boarder is counted as self-employment income for the household.

Medical Programs

The noncommercial roomer/boarder policy is used when an individual in the MAGI household composition receives payments from someone in their physical household under a formal or informal landlord/tenant relationship. Payments made by boarders for room, meals, and other shelter expenses are counted as self-employment income. Payments made by roomers for room and other shelter expenses are counted as self-employment income.

See A-1323.4.5, Allowable Costs of Producing Income, to determine the countable amount of noncommercial roomer/boarder payments. If there is not a formal or informal landlord/tenant relationship, the policy in A-1326.1, Cash Gifts and Contributions, applies.

Related Policy

Nonmembers, A-232.1

A-1323.4.4 Determining the Amount of Self-Employment Income

Revision 16-4; Effective October 1, 2016

All Programs

If the household receives self-employment income monthly or more often (such as semi-monthly, bi-weekly, weekly or daily), recent self-employment pay amounts may be used to project income.

If the household had self-employment income for the past year that was received less often than monthly, the income figures from the previous year's business records or tax forms, including the IRS Schedule C-Form 1040- Profit or Loss from Business, may be used if the records are anticipated to reflect current self-employment income and expenses.

Exceptions:

- If the previous year's records do not accurately represent the household's current self-employment income because the household has experienced a substantial increase or decrease in business, anticipate income using more current information such as updated business ledgers or day books, or contact people who have similar businesses.
- If the business is new and there is insufficient information to make a reasonable projection based on last year's records, anticipate earnings and expenses using only the recent business records along with the individual's statements about expected income and expenses and any applicable information from collateral sources.
- If the income terminates before completing the EDG, budget actual income and expenses for the month the income terminates.
- For Children’s Medicaid programs (TP 43, TP 44, TP 45 and TP 48), the previous year’s business records or tax forms are acceptable, no matter the pay frequency.

When calculating self-employment income, the financial profit from a sale or transfer of capital goods, possessions (such as products, raw materials, equipment), or ownership of a business, must be considered.

Financial profit from the sale or transfer of capital goods that the household expects to receive in the next 12 months should be added and the total averaged over 12 months. This averaged amount should be used for each certification period within the next 12 months, unless a new average is computed because the person received a profit from the sale or transfer of capital goods that was unanticipated or a different amount than anticipated.

Determining the Amount of Self-Employment Income at Application

All Programs

New applicants who have not received TANF, Medical Program coverage, or SNAP for a period of three consecutive months before the application month, or new household members who have not received benefits for three months before moving into the household, may not have been keeping accurate records of self-employment income and expenses. The policy in C-932, Advisor Responsibility for Verifying Information, should be used to obtain verifications needed to determine eligibility and what types of verification are readily available to the household. Any business records that are available for use (even if this documentation is for a short period of time) should be accepted, in addition to the individual's statement and any proof that might be available from a collateral source, as sufficient proof.

The advisor must verify:

- at least the last two recent pay amounts when determining the amount of self-employment income received monthly;
- at least four consecutive recent pay amounts when determining the amount of self-employment income received more often than monthly, such as semi-monthly, bi-weekly or weekly; and
- at least four consecutive weeks for self-employment income received daily.

The individual is not required to provide verification of self-employment income and expenses for more than two calendar months before the interview date for income received monthly or more often.

The applicant's statement is accepted as proof if:

- there is a reasonable explanation why documentary evidence or a collateral source is not available; and
- the applicant's statement does not contradict other individual statements or other information received by the Texas Health and Human Services Commission (HHSC).

Exception: If the business is new and there is insufficient information to make a reasonable projection, the income is calculated based on anticipated earnings and expenses.

The advisor must inform the household in writing to keep self-employment records and receipts for verification purposes for future recertifications. Form TF0001, Notice of Case Action, contains the self-employment information.

Medical Programs

If the individual applies for three months prior Medicaid, the following should be budgeted in each prior month:

- actual income and expenses for self-employment income received monthly or more often, or
- projected monthly average amount for self-employment income received annually or seasonally.

Determining the Amount of Self-Employment Income at TANF Periodic Reviews, SNAP Recertifications, and Medical Programs Renewals

All Programs

For income received less often than monthly, only information from the period of time since HHSC last requested verification of self-employment needs to be verified. Verification that was previously verified is not needed (see C-932). Verification is needed for:

- at least the last two recent pay amounts when determining the amount of self-employment income received monthly;
- at least four consecutive recent pay amounts when determining the amount of self-employment income received more often than monthly, such as semi-monthly, bi-weekly or weekly; and
- at least four consecutive weeks for self-employment income received daily.

The individual is not required to provide verification of self-employment income and expenses for more than two calendar months before the interview date for income received monthly or more often.

If the advisor informed the household to maintain accurate self-employment records and receipts after certification, the household must provide them before being recertified unless:

- the records and receipts are not available because of a reason beyond the household's control, such as being lost in a fire or flood; or
- if due to a verified physical or mental disability, the applicant is unable to complete the task. Note: This requirement is not applicable if the self-employed person has not received TANF, SNAP, or Medical Program coverage for three consecutive months before reapplying.

Related Policy

Computation Methods, A-1323.4.6

A-1323.4.5 Allowable Costs of Producing Income

Revision 25-2; Effective April 1, 2025

All Programs

Allowable self-employment expenses are based on costs that can be deducted from federal income taxes on the Internal Revenue Service's (IRS) Schedule C, Form 1040 - Profit or Loss From Business (PDF). Certain self-employment expense types are not allowed for SNAP.

Use an automatically calculated monthly expense amount generated by TIERS to determine eligibility if the IRS Schedule C, Form 1040 is provided.

Allowable and Non-Allowable Self-Employment Expenses by Program

Expense Types	TANF and MAGI Programs	SNAP
Advertising	Allowable	Allowable
Car and truck expenses	Allowable	Allowable
Commissions and fees	Allowable	Allowable
Contract labor	Allowable	Allowable
Costs not related to self-employment	Non-allowable	Non-allowable
Costs related to producing income gained from illegal activities, such as prostitution and the sale of illegal drugs	Non-allowable	Allowable
Depletion	Allowable	Non-allowable
Depreciation	Allowable	Non-allowable
Employee benefit programs	Allowable	Allowable
Insurance	Allowable	Allowable
Interest	Allowable	Allowable
Legal and professional services	Allowable	Allowable
Net loss that occurred in a previous period	Non-allowable	Non-allowable

Expense Types	TANF and MAGI Programs	SNAP
Office expense	Allowable	Allowable
Pension and profit-sharing plans	Allowable	Allowable
Rent or lease	Allowable	Allowable
Repairs and maintenance	Allowable	Allowable
Supplies	Allowable	Allowable
Taxes and licenses	Allowable	Allowable
Travel, meals, and entertainment	Allowable	Non-allowable
Travel to and from place of business	Non-allowable	Non-allowable
Utilities	Allowable	Allowable
Wages	Allowable	Allowable
Other expenses	Allowable	Allowable

Note: When determining transportation costs, the person may choose to use 70 cents per mile instead of keeping track of actual expenses.

Noncommercial Roomer or Boarder Payments

All Programs

If the household receives roomer or boarder payments the cost of doing business is deducted from each monthly payment. Count the rest as self-employment income.

For roomers, the cost of doing business is actual costs. For boarders, the cost of doing business is:

- the amount of the monthly SNAP allotment for the number of boarders which is the average of more than two meals a day;
- two-thirds of a full allotment for the number of boarders which is the average of two meals a day or less; or
- the actual cost of providing room and meals if the actual cost exceeds the monthly SNAP allotment for the number of boarders.

Note: Each expense must be identified and verified when using actual costs.

Net Financial Loss

All Programs

A self-employment net financial loss must not be deducted from other types of household income.

Exception: The loss may be deducted from other household income if:

- the loss results from a self-employment farming operation; and
- the household received or anticipates receiving an annual gross income of $1,000 or more from the farming operation, using Part I, Line A, Form H1049-3, Self-Employment Income Worksheet.

TANF

The farm loss amount may be deducted from other non-farm self-employment income during the budgetary (100 percent) needs test.

Any remaining farm loss amount may be deducted during the recognizable needs test.

Medical Programs

The farm loss amount may be deducted from other non-farm self-employment income during the federal poverty level (FPL) test.

Any remaining farm loss amount may be deducted after the work expense standard deduction and child or incapacitated care costs.

SNAP

The farm loss may be deducted from other non-farm self-employment income before applying the gross income test.

Any remaining farm loss may be deducted from other earned or unearned income after applying the 20 percent earned income deduction.

Related Policy

Noncommercial Roomer/Boarder Payments, A-1323.4.3

A-1323.4.6 Computation Methods

Revision 15-4; Effective October 1, 2015

All Programs

There are four computation methods for self-employment income that may be used to calculate monthly income amounts for budgeting purposes:

- annual,
- monthly,
- daily, and
- anticipated.

Annual Computation Method

For this method, the individual must have been self-employed for at least the past full year.

The self-employment income projection period, usually 12 months, is the period of time the household expects the income to support the family. A projection period should be established for households that receive self-employment income that is intended to support the household for:

- the year, but is received less frequently than monthly, such as farm income that may only be received a few times per year when crops or livestock are sold; or
- a specific period in time, but is received less frequently than monthly.

The projection period should be determined at application when the individual reports self-employment income received less often than monthly. **Note:** For Medicaid EDGs, if the individual is eligible for prior Medicaid, the prior months are not included in the 12-month projection period.

The following steps are used to determine the projection period for self-employment income:

1. Determine whether the self-employment is annual or seasonal, since that will determine the length of the projection period.
    - Annual – intended to support the household for at least the next full 12 months. The projection period is 12 months whether the income is received yearly or less often than monthly.
    - Seasonal – intended to support the household for less than 12 months since it is available only during certain months of the year. The projection period is the number of months the self-employment is intended to provide support.
2. Determine the first month of the projection period. It is always the first month the household receives benefits, unless the individual will begin working in a future month. In this situation, use the month the self-employment begins as the first month of the projection period.

Once the projection period is established, it must not be changed. The projection period remains the same until the:

- individual no longer supports the household through self-employment;
- 12-month or seasonal period ends; or
- EDG is denied, and the individual misses one full month's benefits before reapplying.

Exception: When there is a new source of self-employment income received less often than monthly, and the individual expects the income to support the household for the year or a specific period of time, establish a projection period for the months that the individual states the income is intended to cover. Since this projection period covers income from a new source, at redetermination, ensure that the income and circumstances still fit with the annual computation method criteria. Until the household has 12 months of income history, the projection period is conditional and may be changed as may the type of computation method used to calculate self-employment income.

In determining the monthly figure to use for new self-employment income when calculating a budget amount:

- the monthly computation method is used if there are two full representative months of self- employment income received less often than monthly; and
- the daily computation method is used if there are less than two full representative calendar months of self-employment income received less often than monthly.

On an active EDG, when an individual reports a new source of self-employment, the first month of the projection period is the change effective month.

Monthly Computation Method

The monthly computation method is used in two situations:

1. If the frequency is known and consistent, the appropriate conversion factor is used when calculating self-employment income and/or expenses. Conversion factors are not used when income is received on any other basis, such as daily or irregularly.

If the frequency is …	use the conversion factor …
weekly	4.33
bi-weekly	2.17
semi-monthly	2

2. If the individual has at least two full representative calendar months of self-employment income and the source or the frequency is unknown and inconsistent, each month's self-employment income should be totaled and deducted from the allowable expenses for each corresponding month.

Daily Computation Method

The daily computation method is used when:

- there are less than two full representative calendar months of self-employment income; and
- the source or frequency of the income is unknown or inconsistent (income received irregularly, not on a weekly, bi-weekly or semi-monthly basis).

The daily method is used until there are at least two representative calendar months of income. Once there are two full representative calendar months, the monthly computation method is used.

Anticipated Self-Employment Method

The anticipated method to calculate self-employment income is used when:

- there is no income history on which to base an average, and the individual will receive the income on a known and consistent basis; or
- there is a change that will make the current or actual self-employment income non-representative.

Anticipated means the individual knows who will pay, when they will pay, and how much will be paid. If the individual knows the source, but not the amount and/or frequency, the daily computation method in A-1323.4.7, Determining Net Self-Employment Income, should be used.

A-1323.4.7 Determining Net Self-Employment Income

Revision 15-4; Effective October 1, 2015

All Programs

Annual Computation Method

The following steps are used to determine net self-employment income when using the annual computation method:

1. Determine the projection period.
2. Determine the total gross self-employment income for the past year.
3. Determine the total allowable expenses for the past year.
4. Determine the yearly net income by subtracting the total allowable expenses from the total gross income.
5. Determine the monthly net income by dividing the total yearly net income by the number of months of earnings history used.

If the self-employment income is annual and no substantial changes are expected, the income should be projected for 12 months. If the self-employment income is seasonal and no substantial changes are expected, the income should be projected for the seasonal period.

Monthly Computation Method

The following steps are used for the monthly computation method:

1. Determine the total monthly gross self-employment income.
2. Determine the total allowable expenses for each corresponding month.
3. Subtract the total allowable expenses from the total gross self-employment income for the corresponding month.
4. Look at the net monthly income and determine which months are representative of future earnings and project over the length of the certification period.

Note: If the frequency is known and consistent, the appropriate conversion factor should be used in Step 1 and Step 2.

Daily Computation Method

The following steps are used for the daily computation method:

1. Determine the total gross income earned from the day the self-employment began through the interview date.

2. Determine the number of days the income was received. The day self-employment begins is the day any part of the self-employment activity occurs (for example, buying supplies, working, earning income, etc.).
3. Divide the total gross income by the number of days in the period the income was received.
4. Multiply the daily income by 30 to get the monthly estimate of gross self-employment income.
5. Determine the total verified self-employment expense paid from the day the self-employment began through the interview date.
6. Determine the number of days the expense was to cover. Use the same number of days used to calculate income.
7. Divide the total expense amount by the number of days in the period.
8. Multiply the daily expense deduction by 30 to get the monthly estimate of the expense.
9. Subtract monthly expenses from gross monthly income to determine net monthly self-employment.

Anticipated Self-Employment Method

The following steps are used for the anticipated self-employment method:

1. Determine how often the individual will be paid and the amount.
2. Multiply the pay amount by the appropriate frequency to determine the projected monthly amount:
    - Weekly: amount x 4.33
    - Bi-weekly: amount x 2.17
    - Semi-monthly: amount x 2

    Note: If the income amounts will fluctuate, a pay period average should be determined and multiplied by the appropriate conversion factor.
3. Projection should be made over the length of the certification period.

Related Policy

How to Project Income, A-1355
Length of Certification, A-2324

A-1323.4.8 Changes in Annual or Seasonal Self-Employment Income

Revision 15-4; Effective October 1, 2015

All Programs

When an individual reports a change in self-employment income during the certification period, it should be considered part of the normal fluctuations of the business if the current budget already includes fluctuations as significant as the change that the individual is reporting, and the budget is not revised. If a reported change is not part of the normal fluctuations of the business, the income and expenses should be re-evaluated and the change considered substantial if it results in a change to the average monthly net self-employment income of more than $25. If the change results in a change of $25 or less, benefits should not be adjusted.

If a 12-month income projection period was previously established, the period should not be changed, unless it has expired or the individual reports no longer supporting the household with self-employment income. Even if the income or expense changes resulted in a different projected self-employment income, the projection period is the same.

If the income projection period has expired, a new projection period should be established with required verifications, even if the individual indicates no changes in the business.

Note: When the individual reports a change in self-employment income that is not received annually or seasonally, the policy in B-631, Actions on Changes, should be followed.

A-1323.4.9 Rebudgeting Income and Expenses

Revision 15-4; Effective October 1, 2015

All Programs

If the individual reports a substantial change in annual or seasonal self-employment income, the income and expenses must be rebudgeted using the following method for actual income and expenses received.

Actual income from the beginning of the projection period through the month before re-evaluation should be used. The following steps are used to rebudget income in this situation.

1. Determine the actual income for the months from the beginning of the projection period through the month before re-evaluation.
2. Project the new income for the rest of the projection period.
3. Add the income from Step 1 and 2 to determine the annual or seasonal amount.

4. Divide the total from Step 3 by 12 or the number of months in the seasonal period to get the new monthly average.
5. Compare the new monthly amount to the previous average. If the change is substantial, budget the new amount over the remainder of the projection period.

A-1323.5 Wages, Salaries, Commissions, and Tips

Revision 21-2; Effective April 1, 2021

All Programs

Except for MAGI Medical Programs, the gross amount of all wages, salaries, commissions, bonuses, and tips count as earned income before deductions. This includes flexible fringe benefits, cafeteria plans, and employee retirement contributions that are withheld from the amount. MAGI Medical Programs exclude pre-tax contributions from gross income.

Wages held by the employer at the request of the employee and garnished wages are counted as income in the month the household would otherwise have received them. If an employer holds the employee's wages as a general practice, this money counts as income in the month it is actually received by the employee.

An advance counts in the month it is received. When an advance is repaid, the payback amount is deducted from the gross pay in the month it is paid back and the remainder is budgeted as the countable gross amount.

Medical Programs

Review income verification documents to determine if the person makes pre-tax contributions through their employer.

Pre-tax contributions are deducted before the gross income is taxed and must be excluded when determining MAGI countable gross income. Pre-tax contributions consist of the following:

- Retirement Savings Accounts (401K, 457, etc.);
- Dependent Care Flexible Spending Accounts;
- Health Savings Accounts;
- Health Insurance Premiums;
- Commuter Expenses Accounts; and
- Life Insurance Premiums.

Pend the EDG if the person claims pre-tax contributions, but verification is not provided. If verification is not provided by the due date, do not exclude the pre-tax contribution from the employment income. Count the gross income including the pre-tax contribution amounts. Staff must not deny the EDG for failure to provide pre-tax contribution information.

Related Policy

How to Project Income, A-1355
Budgeting Options for SNAP Households, A-1355.1

A-1323.5.1 Federal Tax Refunds and Earned Income Tax Credits (EIC)

Revision 21-2; Effective April 1, 2021

All Programs

Households with earnings below levels established by the Internal Revenue Service (IRS) are potentially eligible to receive EIC payments from the IRS.

EIC money is included in a person's:

- paycheck (advance EIC payments) before the person files an income tax return, or
- IRS refund after the person files an annual income tax return.

Federal tax refunds and EIC payments are exempt as income.

Related Policy

Federal Tax Refunds and Earned Income Tax Credits (EIC), A-1232.2

A-1323.5.2 Flexible Fringe Benefits

Revision 15-4; Effective October 1, 2015

All Programs

Fringe benefit plans allow the employee to choose from benefit components such as insurance, extra vacation time, and payments to third parties for medical bills or child care. These are also called "cafeteria plans."

Under some plans, employers may:

- withhold wages to pay for benefits selected by the employee; or
- offer benefit credits in addition to wages, which the employee can use to purchase benefits.

Some plans may pay the remaining unused credit as part of the employee's wages.

TANF and SNAP

If the employer …	the advisor must count …
withholds the employee's wages to purchase benefits,	the held wages as earnings in the pay period that the employee would have normally received them.
provides credit in addition to wages,	as earnings only the portion that is paid directly to the employee. If the employer pays the unused credit in cash, the advisor must follow the steps below to determine countable excess income. 1. Determine the total amount of gross wages/salary. 2. Add the benefit credit amount to the wages/salary from Step 1. 3. Subtract the cost of fringe benefits up to the amount of the benefit credit from the amount in Step 2. 4. The remaining income from Step 3 is the countable gross earned income for the EDG.

Medical Programs

Flexible fringe benefits are exempt.

A-1323.5.3 Income from Tips

Revision 15-4; Effective October 1, 2015

All Programs

Household members who are employed in service-related occupations (beauticians, waiters, delivery staff, etc.) are likely to earn tips in addition to wages. Tips are counted as earned income.

Tip income is added to wages before applying conversion factors.

Note: Tips are not considered as self-employment income unless related to a self-employment enterprise.

A-1323.5.4 Vacation Pay

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If an individual receives vacation pay …	the payment is considered …
during or before termination of employment,	earned income.
after termination of employment in one lump sum,	a liquid resource in the month received.
after termination of employment in multiple checks,	unearned income.

Medical Programs

Vacation pay is counted as unearned income.

Related Policy

Lump-Sum Payments, A-1242 and A-1331

A-1323.6 Temporary Census Income

Revision 20-3; Effective July 1, 2020

TANF, SNAP, TP 32 and TP 56

Wages paid by the Census Bureau for temporary employment related to census activities are exempt.

Medical Programs except TP 32 and TP 56

Wages paid by the Census Bureau for temporary employment related to census activities are counted as earned income.

A-1324 Government Payments

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Government payments are counted unless exempted in this section or by other policy in A-1300, Income.

Medical Programs

Government payments are exempt.

A-1324.1 Adoption Assistance

Revision 15-4; Effective October 1, 2015

All Programs

Adoption assistance payments are exempt.

Note: A person receiving adoption assistance in a TANF budget or a certified group is exempt.

Related Policy

Who Is Not Included, A-222

A-1324.2 Crime Victim's Compensation Payments

Revision 15-4; Effective October 1, 2015

All Programs

Crime victim's compensation payments are provided from the funds authorized by state legislation to assist a person who:

- was a victim of a violent crime;
- was the spouse, parent, sibling, or adult child of a victim who died as a result of a violent crime; or
- is the guardian of a victim of a violent crime.

The Office of the Attorney General (OAG) distributes the payments monthly or in a lump sum. These payments are exempt.

Related Policy

Crime Victim's Compensation Payments, A-1232.1

A-1324.3 Government Disaster Payments

Revision 15-4; Effective October 1, 2015

All Programs

Federal disaster payments and comparable disaster assistance provided by states, local governments, and disaster assistance organizations are exempt if the household is subject to legal penalties when the funds are not used as intended (including temporary employment of six months or less for disaster-related work, paid under the Workforce Innovation and Opportunity Act and funded by the National Emergency Grant).

Examples:

- Payments by the Individual and Family Grant Program or Small Business Administration to rebuild a home or replace personal possessions damaged in a disaster.
- Payments from the Federal Emergency Management Agency (FEMA) to assist with rent.

Related Policy

Government Disaster Payments, A-1232.4

A-1324.4 Government Housing Assistance

Revision 15-4; Effective October 1, 2015

All Programs

See A-1326.3, Energy Assistance, for energy or utility payments.

TANF and Medical Programs

The value of government housing or rental subsidies, whether cash, two-party check, in-kind, or vendor-paid, are exempt.

SNAP

The following payments are counted:

- cash payments;
- vendor payments paid from state or local government funds unless exempt as shown below; and
- vendor payments paid from state or local funds for transitional housing for the homeless.

The following payments are exempt:

- in-kind payments; and
- federally funded vendor or two-party check payments.

A-1324.5 Transitional Living Allowance

Revision 15-4; Effective October 1, 2015

All Programs

Transitional living allowances (TLA) are exempt. The Texas Department of Family and Protective Services (DFPS) distributes TLA to a foster child who:

- is under age 21;
- has completed the preparation for adult living (PAL) classes; and
- has left foster care or is transitioning out of foster care.

Payments:

- are received for a maximum of 12 months;
- cannot exceed $500 a month;
- cannot total more than $1,000; and
- are intended for expenses other than ongoing room and board.

Related Policy

Transitional Living Allowance, A-1232.5

A-1324.6 Reserved for Future Use

Revision 18-3; Effective July 1, 2018

A-1324.7 Community Service Programs

Revision 24-3; Effective July 1, 2024

All Programs

The National and Community Service Act of 1990 (NCSA) established a corporation to administer paid volunteer service programs. The corporation provides funds, training and technical assistance to states and communities to develop and expand human, education, environmental and public safety services.

The corporation oversees programs created under the Domestic Volunteer Service Act (DVSA) of 1973 such as:

- Volunteers in Service to America (VISTA);
- Retired and Senior Volunteer Program (RSVP);
- Foster Grandparents; and
- Senior Companions.

The corporation also administers programs established in 1993 that include:

- AmeriCorps;
- Learn and Serve; and
- National Senior Service Corps (Senior Corps).

For programs established in 1973:

Payments, living allowances and stipends are exempt.

For programs established in 1993:

Exempt payments except on-the-job training (OJT) payments. OJT payments are:

- counted as earned income for adults; and
- exempt for:
    - AmeriCorps volunteers; and
    - children 19 and younger under the parental control of another household member.

Medical Programs

Use the exceptions for counting a child's OJT income in the MAGI household income. Refer to related policy for Medical Programs, **Step 3.**

SNAP

VISTA payments under Title I of the DVSA of 1973 are:

- exempted only if the person received SNAP before participating in the VISTA program; and
- counted as earned income for a person who applies for SNAP while already participating in the VISTA program.

Exempt payments under Title V of Public Law 106-501, the Community Service Employment Program for Older Americans, which was formerly known as the Senior Community Service Employment Program.

Related Policy

Income Limits and Eligibility Tests, A-1341

A-1324.8 Native and Indian Claims

Revision 20-3; Effective July 1, 2020

TANF and SNAP

Exempted payments made to Native Americans under various public laws include, but are not limited to, the following:

- Distributions from Native Corporations made under the Alaska Native Claims Settlement Act (ANCSA) (Public Law [PL] 92-203 and Section 15 of PL 100-241).
- Funds distributed per capita or held in trust by the Indian Claims Commission for members of Indian tribes, as follows:

    - Grand River Band of Ottawa Indians (PL 94-540);
    - Income to certain tribal members from land held in trust by the United States government (PL 94-114, Section 6);
    - Income resulting from provisions of PL 92-254; and
    - Red Lake Band of Chippewa (PL 98-123, Section 3) or Assiniboine Tribe of the Fort Belknap Indian Community, and the Assiniboine Tribe of the Fort Peck Indian Reservation (PL 98-124, Section 5).
- Funds distributed by the Secretary of the Interior to tribal members from:
    - tribal trust funds on a per capita basis (PL 98-64); or
    - judgment funds up to $2,000 per year, per person, from claims against the United States and held in trust or distributed on a per capita basis (PL 93-134, as amended by 97-458).
- Payments by the Indian Claims Commission to the:
    - Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians or any of their members [Maine Indian Claims Settlement Act of 1980, PL 96-420, Section 9(c)].
    - Confederated Tribes and Bands of Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL 95-433).
    - Seneca Nation or its members (Seneca Nation Settlement Act of 1990, PL 101-503).
    - Blackfeet, Gros Ventre, and Assiniboine tribes of Montana (PL 97-408).
    - Saginaw Chippewa of Mississippi [PL 99-123, Section 6(b)(2)].
- Payments to the Turtle Mountain Band of Chippewa, Arizona (PL 97-403).
- Payments $2,000 per year, per person, to heirs of deceased Indians made under the Old Age Assistance Claims Settlement Act (PL 98-500).

Exception: Money given to Native Americans from gaming revenues (such as from casino profits, race tracks, lotteries, etc.) is not exempt under these laws. Gaming revenues are counted as unearned income.

Medical Programs

American Indian/Alaskan Native (AI/AN) disbursement income is exempt and not counted under MAGI only if the person claiming that income type has verified their AI/AN status and provided verification of the income source, as explained in A-1370, Verification Requirements, for Medical Programs.

AI/AN disbursements include:

- distributions from Alaska Native corporations and settlement trusts;
- distributions from property held in trust, in the boundaries of a prior federal reservation;
- distributions and payments from rents, leases, rights of way, royalties, usage of rights, or using natural resources from land under the supervision of the Secretary of the Interior or rights to off-reservations hunting, fishing, gathering, or natural resource usage;
- payments from ownership/usage rights to items that are religious, spiritual, traditional, or cultural or rights that support subsistence/traditional lifestyle according to tribal law or custom; and
- student financial assistance from the Bureau of Indian Affairs education program.

A-1324.9 Nutrition Programs

Revision 15-4; Effective October 1, 2015

All Programs

The following amounts are exempt:

- the value of food assistance under the Child Nutrition Act of 1966 and under the National School Lunch Act; and
- benefits received under Title VII, Nutrition Program for the Elderly, of the Older American Act of 1965.

A-1324.10 One-Time TANF for Relatives

Revision 22-2; Effective July 1, 2022

All Programs

One-Time TANF for Relatives payments are exempt as income.

Related Policy

One-Time TANF for Relatives, A-2412

A-1324.11 One-Time Temporary Assistance for Needy Families (OTTANF)

Revision 15-4; Effective October 1, 2015

All Programs

OTTANF is exempt as income.

A-1324.12 Payments to Vietnam Veterans' Children

Revision 03-7; Effective October 1, 2003

A-1324.12.1 Payments to Vietnam Veterans' Children Born with Spina Bifida (Public Law 104-204)

Revision 15-4; Effective October 1, 2015

All Programs

These VA payments made to Vietnam veterans' children who are born with spina bifida are exempt.

A-1324.12.2 Payments to Children of Women Vietnam Veterans Born with Certain Birth Defects (Public Law 106-419)

Revision 15-4; Effective October 1, 2015

All Programs

VA payments made to the children of women Vietnam veterans who are born with a birth defect are exempt.

Related Policy

Payments to Children of Women Vietnam Veterans Born with Certain Birth Defects (Public Law 106-419), A-1232.7.2

A-1324.13 Payments to Victims of Nazi Persecution

Revision 15-4; Effective October 1, 2015

All Programs

Payments made to individuals because of their status as victims of Nazi persecution are exempt.

A-1324.14 Payments to World War II Filipino Veterans and Spouses

Revision 15-4; Effective October 1, 2015

All Programs

Under the American Recovery and Reinvestment Act of 2009 (Division A, Title X, Section 1002), some World War II Filipino veterans who served in the military forces of the Government of Commonwealth of the Philippines, and their spouses, are authorized to receive one-time lump-sum payments of up to $15,000.

These payments are exempt.

A-1324.15 Relocation Assistance

Revision 25-3; Effective July 1, 2025

All Programs

Exempt the payments provided under the following:

- Title II of the Uniform Relocation Assistance and Real Property Acquisitions Act of 1970;
- Title I of Public Law 100-383 (payments to Aleuts or individuals of Japanese ancestry [or their heirs] who were relocated during World War II); or

- Public Law 93-531, relocation assistance payments to members of the Navajo or Hopi Tribes.

Related Policy

Relocation Assistance, A-1232.12

A-1324.16 Retirement, Survivors and Disability Insurance (RSDI)

Revision 18-4; Effective October 1, 2018

All Programs

The benefit amount, including the deduction for the Medicare premium, less any amount being recouped for a prior RSDI overpayment, is counted as unearned income.

Note: If DFPS is the payee and the child gets Foster Care Medicaid:

- **No Cash**, the RSDI income is counted; or
- **With Cash**, the RSDI income is exempt.

See A-1326.15, Income Legally Obligated to Children in Department of Family and Protective Services (DFPS) Conservatorship, for more information on foster care types of assistance.

Note: SSA may deposit RSDI benefits into a Direct Express card debit account. See Get Your Payments Electronically (PDF).

For people who meet a MAGI exception as defined under Step 3 in A-1341, Income Limits and Eligibility Tests, calculate the countable amount of the person's RSDI using the formula in Table 3, Step 3 of the Form H1042, Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP.

Related Policy

Debit Accounts, A-1231.2
Income Limits and Eligibility Tests, A-1341

A-1324.17 Supplemental Security Income (SSI)

Revision 17-1; Effective January 1, 2017

TANF

The income of an SSI recipient is exempt.

If the SSI recipient contributes to a member of the TANF unit, the contributions policy in A-1326.1.1, Contributions from Noncertified Household Members, applies.

Exception: All of the SSI benefits are exempt when the SSI recipient meets one of the following criteria.

- The SSI recipient would otherwise be an eligible member of the TANF unit.
- The SSI recipient would otherwise be someone whose income is "applied" to the TANF unit.
- A TANF-certified member is the SSI recipient's payee.

Note: This policy applies to people who cannot get SSI financial assistance because of earnings but who continue to get SSI Medicaid.

SNAP

Counted as unearned income. The following amounts are deducted if the amount is being:

- recouped for an SSI overpayment; or
- collected by a qualified organization providing representative payee services, up to the lesser of 10 percent of the monthly benefit amount or:
  - $50 for SSI benefits based on alcoholism and/or drug abuse (SSI/DAA); or
  - $25 for non-SSI/DAA benefits.

Notes:

- Advisors must verify with SSA that the qualified organization is authorized to collect a fee for representative payee services. The advisor must also verify with the qualified organization the amount collected for representative payee services.
- If DFPS is the payee and the child gets Foster Care Medicaid:
  - **No Cash**, the SSI income is counted; or
  - **With Cash**, the SSI income is exempt.

A-1326.15, Income Legally Obligated to Children in Department of Family and Protective Services (DFPS) Conservatorship, includes more information on foster care types of assistance.

Note: SSA may deposit SSI benefits into a Direct Express card debit account. See Get Your Payments Electronically (PDF).

Medical Programs

SSI is exempt. Count the other income of an SSI recipient unless the income is exempt.

Related Policy

Plan for Achieving Self-Sufficiency (PASS), A-1326.8
Debit Accounts, A-1231.2

A-1324.18 Temporary Assistance for Needy Families (TANF)

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

TANF benefits are exempt from income.

SNAP

The TANF benefit amount (after recoupment) counts as unearned income.

Retroactive or restored TANF or refugee cash assistance payments are exempt as income. These payments should be considered lump-sum payments and counted as a resource.

Note: TANF benefits may be deposited into an Electronic Benefit Transfer (EBT) cash debit account and made accessible to recipients via an EBT card.

Exception: The recommended grant amount continues to be counted when the TANF grant is lowered for one or more of the following reasons:

- a Personal Responsibility Agreement (PRA) penalty;
- a recoupment for a TANF intentional program violation (IPV);
- a disqualification for IPV or noncooperation with a TANF requirement (unless the individual is disqualified in SNAP for the same offense); or
- an active TANF EDG is denied because of:
  - the noncooperation disqualification of an individual;
  - failure to sign Form H1073, Personal Responsibility Agreement;
  - PRA noncooperation; or
  - noncooperation with an audit or investigation.

SNAP benefits must not be increased in an existing certification period when TANF benefits are forfeited because of a noncooperation penalty. In situations where the TANF is denied:

- the full TANF benefit is counted until the next SNAP certification period begins; and
- the benefit continues to count when a SNAP certification period is extended.

In situations where there is a break in SNAP benefits of less than a month, the TANF continues to count through the next certification period when the:

- individual received or will receive SNAP in the month of the PRA noncooperation, and either the first or second noncooperation month is also the first month of a new SNAP certification period; or
- file date of the SNAP application and the TANF PRA noncooperation date are the same month, and SNAP benefits do not prorate to less than $10 in the month of application.

Note: This policy does not apply to other types of TANF disqualifications or denials or to denied TANF applications.

Examples:

During the SNAP certification period January – June, the date of noncooperation is February 1. The first noncooperation month is February, and the second noncooperation month is March. The TANF grant is denied in April. The TANF grant continues to count in the SNAP budget through June.

At a SNAP redetermination when there is a certified TANF EDG, the household fails to comply with TANF PRA requirements and is denied effective with March benefits. The date of noncooperation is January 1. The first noncooperation month is January, and the second noncooperation month is February. The SNAP application file month is January. When the SNAP redetermination is untimely in January:

- because the last benefit month was December, the TANF **counts** in the ongoing SNAP budget since there is not at least a one-month break in SNAP benefits.
- and the last benefit month was November, the TANF **does not count** in the forfeit and ongoing months because there is a break in SNAP benefits of one month or more. The TANF grant received in January, the month of redetermination, must be counted.
- because the last benefit month was December, and the SNAP benefit prorates to zero for the application month, the application month is considered a break in benefits of at least one month. The TANF grant **does not count** in the forfeit or ongoing months.

When the SNAP redetermination is a new application or the individual was receiving SNAP in a different household, the TANF **does not count** in the forfeit or ongoing months. However, the TANF grant received in January, the month of application, must be counted.

A-1324.18.1 TANF Annual School Subsidy Payment

Revision 15-4; Effective October 1, 2015

All Programs

TANF annual school subsidy payments are exempt.

A-1324.19 Unemployment Compensation

Revision 15-4; Effective October 1, 2015

All Programs

Unemployment insurance benefits (UIB) are:

- deposited into a debit account and accessible to claimants via the UIB debit card;
- deposited directly into a personal checking or savings account; or
- issued through a mailed paper check.

The gross UIB benefit, less any amount being recouped for a UIB overpayment, counts as unearned income.

Exception: The gross amount counts if the household agreed to repay a SNAP overpayment through voluntary garnishment.

Related Policy

How to Project Income, A-1355
Debit Accounts, A-1231.2
Payments Exempt as a Resource While Being Considered Income, A-1243

A-1324.20 Veterans Benefits

Revision 15-4; Effective October 1, 2015

All Programs

The VA provides payments to veterans with disabilities and/or their spouses/dependents and to spouses/dependents of deceased veterans. VA benefits are not subject to federal or state income tax or child support garnishment.

Three basic VA benefit programs are described in this section:

- Pension,
- Disability Compensation, and
- Dependency and Indemnity Compensation (DIC).

VA Pension

VA pension payments are made to certain veterans with disabilities based on financial needs. Low-income veterans who either have a disability or are age 65 and older may be eligible for a VA pension if they have 90 days or more of active military service with at least one day during a period of war. Payments are made to bring the veteran's total income, including other retirement or Social Security income, to a level set by Congress. Recipients must re-qualify each year to continue to receive payments. There is a similar pension benefit available for surviving spouses and dependent minor children of such deceased veterans.

VA Disability Compensation

VA disability compensation is a payment made to a veteran with a service-related disability. Eligibility is not based on financial need. The amount of the payment varies with the percentage of the veteran's disability and the number of the veteran's dependents living in or out of the home. The payment can also be made to a spouse, child or parent of a veteran because of the service-related death of the veteran.

Dependency and Indemnity Compensation

DIC is a monthly benefit paid to eligible survivors of active duty service members and survivors of those veterans whose deaths are determined by VA to be service-related. This payment is a flat monthly payment, regardless of other income. The payment is payable for the life of the spouse, provided the spouse does not remarry before age 57; however, should a remarriage end, DIC benefits can be reinstated. This payment is adjusted annually for cost-of-living increases and is non-taxable. VA adds a monthly transitional payment to the surviving spouse with minor children for the first two years of DIC entitlement or until the last child turns age 18, whichever occurs first.
See http://benefits.va.gov/Compensation/current_rates_dic.asp for current payment amounts.

Veterans with certain disabilities may be eligible for additional special monthly compensation such as:

- Aid and Attendance and Housebound payments, which are an allowance to veterans and dependents who are in need of regular aid and attendance by another person, or a veteran who is permanently housebound; and
- reimbursement for unusual medical expenses.

TANF and SNAP

The gross benefit less any amount recouped or suspended for VA overpayment is counted as unearned income, except as described below for reimbursement for medical and attendant care expenses.

These special compensation payments that are intended to cover medical and attendant care expenses are exempt. These payments are exempt as reimbursement as explained in A-1332, Reimbursements.

Apportioned VA payments are a direct payment of the dependent's portion of the VA benefit to a dependent spouse or child not living with the veteran. Apportioned VA payments are unearned income to the dependent spouse or child not living with the veteran.

Other Types of Veterans Benefits

- Military retirement payment — A payment made to an individual who retired from active duty military service after at least 20 years of service. Military retirement is not a VA program, but is paid by the Defense Finance and Accounting Service in Cleveland (DFAS-CL). The gross payment is counted as unearned income.
- Survivor Benefit Plan (SBP) — Active duty members are automatically enrolled in this program. Surviving spouses and/or children of service members who die while on active duty may be entitled to SBP payments made by DFAS-CL. SBP payments are equal to 55 percent of what a member's retirement pay would have been had the member been retired at 100 percent disability. An SBP payment is reduced by the amount of payments provided under the VA DIC program.

At retirement, retirees may choose to purchase the SBP. In this case, the SBP pays retired military members' eligible survivors an inflation-adjusted monthly income. Basic SBP for a spouse pays a benefit equal to 55 percent of the retired individual's pay. Eligible children may also be SBP beneficiaries while they are dependents of the retired individual, either alone or added to spouse coverage. Any VA DIC paid to a spouse is subtracted from SBP payments, although VA DIC payments to or for children do not affect SBP payments. SBP premiums are refunded to the survivor if the monthly VA DIC amount is greater than the SBP monthly annuity.

The gross amount of any SBP payment is counted as unearned income.

- VA educational assistance programs — Different programs provide education assistance, including vocational rehabilitation. The policy in A-1322.1, Educational Assistance, applies.

Medical Programs

All veterans benefits are exempt from income

A-1324.21 Relative and Other Designated Caregiver Program Payments

Revision 19-1; Effective January 1, 2019

All Programs

There are two types of Relative and Other Designated Caregiver Program Payments issued by DFPS, these include:

- Kinship Reimbursement payments; and
- Post-Permanent Managing Conservatorship Annual Reimbursement payments.

Both of these types of payments are exempt from income.

Related Policy

Relative and Other Designated Caregiver Program Payments, A-1232.13

A-1324.22 Healthy Marriage Development Program Payments

Revision 15-4; Effective October 1, 2015

All Programs

A payment received for completing the Healthy Marriage Development Program is exempt. The advisor must document as required by policy in A-1380, Documentation Requirements.

A-1324.23 Railroad Retirement Benefits

Revision 18-4; Effective October 1, 2018

Railroad retirement benefits may be paid to a person, the person's dependents or survivors. Some examples of railroad retirement benefits are sick pay, annuities, pensions and unemployment insurance benefits.
Count the gross benefit amount, including the deduction for the Medicare premium as unearned income.

Exception: For Medicaid and Children's Health Insurance Program (CHIP), people who meet a MAGI exception as defined under Step 3 in A-1341, Income Limits and Eligibility Tests, calculate the countable amount of the person's railroad retirement benefits using the formula in Table 3, Step 3 of the Form H1042, Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP.

Related Policy

Income Limits and Eligibility Tests, A-1341

A-1325 Income from Property

Revision 02-8; Effective October 1, 2002

A-1325.1 Dividends and Royalties

Revision 15-4; Effective October 1, 2015

All Programs

Dividends count as unearned income. Exception: Dividends from insurance policies are exempt as income.

TANF and SNAP

Royalties count as unearned income, less any amount deducted for production expenses and severance taxes.

Medical Programs

Royalties count as unearned income. For allowable expenses, see A-1420, Types of Deductions.

A-1325.2 Payments for Oil, Gas, and Mineral Rights

Revision 15-4; Effective October 1, 2015

All Programs

Payments for oil, gas, and mineral rights count as unearned income.

A-1326 Other

Revision 08-1; Effective January 1, 2008

A-1326.1 Cash Gifts and Contributions

Revision 18-1; Effective January 1, 2018

TANF and SNAP

Cash gifts and contributions count as unearned income unless they:

- are made by a private, nonprofit organization on the basis of need; and
- total $300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January to March, April to June, July to September, and October to December.

If these contributions exceed $300 in a quarter, the excess amount counts as income in the month received.

Exception: Contributions from noncertified household members are budgeted according to policy explained in A-1326.1.1, Contributions from Noncertified Household Members.

Medical Programs

Count cash support only if:

- it is given from a taxpayer to his or her tax dependent;
- it is given by a taxpayer who is someone other than the receiver's spouse or parent; and
- the total amount exceeds $50 a month.

For example, a person gives $100 a month to her nephew and plans to claim her nephew as her tax dependent. This cash support will count for her nephew because the she is a taxpayer giving an amount to her tax dependent. She is not her nephew's parent or spouse, and the amount exceeds $50 a month.

Related Policy

Energy Assistance, A-1326.3
Lump-Sum Payments, A-1242 and A-1331
MyGoals Payments, A-1326.27

A-1326.1.1 Contributions from Noncertified Household Members

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If a noncertified person(s) lives in the home with a TANF/SNAP unit and shares household expenses (no landlord/tenant relationship), any payments the noncertified person makes to the unit for common household expenses (including food, shelter, utilities, and items for home maintenance) are exempt. If a noncertified household member makes additional payments for use by a certified member, it is a contribution.

If a noncertified household member makes payments to a certified member under a formal or informal landlord/tenant relationship, countable income is determined according to the roomer/boarder policy in A-1323.4.3, Noncommercial Roomer/Boarder Payments.

Medical Programs

For contributions from noncertified household members, advisors must follow the policy explained in A-1326.1, Cash Gifts and Contributions, for Medical Programs.

A-1326.1.2 Gifts from Tax-Exempt Organizations

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Gifts from tax-exempt organizations are exempt if the gift is for a child with a life-threatening condition and the amount of the gift is:

- less than $2,000 annually, and
- not converted to cash.

If the gift is converted into cash or exceeds $2,000 a year, the conversion or the excess counts as unearned income in the month of receipt and is exempt as a resource in the months that follow.

Medical Programs

See A-1326.1, Cash Gifts and Contributions, for Medical Programs.

A-1326.2 Child Support

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Payments obtained on behalf of a child count as unearned income. See A-1326.2.1, Counting Child Support, for when to count for Temporary Assistance for Needy Families. Payments are considered as child support if:

- a court ordered the support, or
- the child's caretaker or the person making the payment states the purpose of the payment is to support the child.

Child support collections distributed through the Texas OAG may be received through warrants, direct deposits or the Texas Debit Card. Refer to A-1326.2.1 for the various methods and availability.

Child support payments may be received by a person in Texas through another state's Office of Attorney General. Several other states use debit accounts for the distribution of child support payments.

Note: If DFPS is the payee and the child receives Foster Care Medicaid:

- **With Cash**, child support is exempt.
- **No Cash**, the child support income is counted.

Advisors must contact DFPS child support representatives to verify the amount of child support and dates of disbursements because DFPS may not forward the total legally obligated amount. OAG inquiries are not used in this situation.

See A-1326.15, Income Legally Obligated to Children in Department of Family and Protective Services (DFPS) Conservatorship, for further information on foster care types of assistance.

Advisors must consider the following in determining child support:

- Gifts or donations as contributions are not considered child support. Gifts are items or money that only benefit the child for a specific purpose, such as a birthday present. These gifts or donations include (but are not limited to) clothes, toys, or personal items, or money to purchase clothes, toys, or personal items.
- Ongoing child support income is considered as income to the children, even if someone else living in the home receives it.
- Child support arrears is considered as unearned income to the caretaker.

If an absent parent is making child support payments but moves back into the home of the caretaker and child, the child support is not counted. The earnings and/or other income count as a regular household member.

If a caretaker receives current child support for a nonmember (or a member who is no longer in the home) but uses the money for personal or household needs, the amount counts as unearned income. The amount actually used for or provided to the nonmember for whom it is intended to cover is not counted.

If a single payment covers two or more children (including at least one who is not an applicant/recipient) and the support order does not specify a portion for each child, the payment is prorated among all of the children. When two or more children receive child support from the same father and one child receives Supplemental Security Income, the payment is always prorated.

Medical Programs

Child support is exempt.

A-1326.2.1 Counting Child Support

Revision 15-4; Effective October 1, 2015

TANF and SNAP

For child support payments issued via …	funds are …
warrants,	mailed from Austin, Texas, the day after the disbursement date listed on the Texas Child Support Enforcement System (TXCSES) inquiry system. When determining availability, consider the distance the payment has to travel through the mail.
direct deposit/electronic transfers,	available two business days after the disbursement date listed on the TXCSES Web inquiry system.
Texas debit cards,	available two business days after the disbursement date listed on the TXCSES Web inquiry system.

Related Policy

How to Project Income, A-1355
Debit Accounts, A-1231.2

TANF

Applicants are not required to remit any child support received before the certification date. At application and prior to certification, the following procedures may be used to determine the countable child support to budget.

When determining …	count …
eligibility,	all child support already received and/or expected to be received each month, less the $75 disregard. If the countable child support plus other countable income is less than the TANF recognizable needs, proceed to determining the benefit amount.
benefits,	child support received from the beginning of the month through the date of certification, less the $75 disregard. **Exception:** For One-Time TANF, issue the full grant.

Note: If the applicant refuses to remit the child support after signing Form H1073, Personal Responsibility Agreement, prior to certification, a child support penalty is applied.

TANF recipients should be instructed to remit all child support received after the certification date to the OAG. See A-1124, TANF, for instructions on remitting child support payments to the state. Child support payments remitted to the OAG as required are not counted.

Child support received after certification is counted **if** the:

- individual receives an excess payment from the OAG; or
- legal parent keeps payments received directly from the absent parent instead of remitting them to the state.

A sanction is imposed for noncooperation. Child support payments are counted, less the $75 disregard deduction. The advisor must process a claim for any overissuance.

SNAP

Child support counts as unearned income. If a TANF individual remits child support to the state, only the portion the OAG sends to the individual is counted.

Computer Action on Disregard Payment

The OAG sends HHSC a monthly computer tape for all TANF individuals receiving OAG child support payments that month. Each month, the Texas Integrated Eligibility Redesign System (TIERS):

- updates the child support payment history file on SNAP data inquiry; and
- rebudgets any associated SNAP EDG not correctly budgeted. This rebudgeting results in an automated Form TF0001, Notice of Case Action, if rebudgeting results in adverse action.

TANF-State Program

Full child support payments are counted, less the $75 disregard deduction.

A-1326.2.2 Lump-Sum Child Support Payments

Revision 22-2; Effective April 1, 2022

TANF and SNAP

Lump-sum child support payments received or anticipated to be received more often than once a year count as unearned income in the month received. Lump-sum child support payments received once a year or less frequently count as a resource in the month received.

Lump-sum payments on child support arrears are received from the following sources:

- **IRS intercept program** — This occurs when the IRS intercepts the absent parent's tax refund to pay child support arrears.
- **Excess payment** — When the OAG sends a second excess payment to the recipient, HHSC receives the payment date and amount.
- **OAG adjustments** — HHSC receives a PBS-OAGF1 Report, Clients Receiving a Lump Sum Adjustment from OAG-Possible Ineligibility. HHSC produces this report when the OAG adjusts an EDG that results in a lump-sum distribution to the recipient. Adjustments may occur when federal distribution changes are implemented, court orders are modified, or EDG errors are corrected.

Lump-sum payments on current child support are received from the following sources:

- **Advance pay** — Advance pay occurs when the absent parent is current on obligated amounts and voluntarily pays an amount in advance of the obligated monthly amount. **Example:** The absent parent is obligated to pay $200 a month and is current on that amount. The absent parent loses their job and receives a severance payment of $2,000 and decides to pay $1,000 in advance to cover child support for the next five months. The payment to the recipient counts as a resource in the month received.
- **Future pay** — Future pay occurs when the absent parent is current on obligated amounts and voluntarily and routinely pays an extra amount over the obligated amount. **Example:** The absent parent is obligated to pay $200 a month and is current on that amount. The absent parent pays $25 extra each month (or some months). The OAG releases the money as received. This payment counts as unearned income if staff anticipate that it will be received more often than once a year.

Related Policy

Lump-Sum Payments, A-1242
Calculating Household Income, A-1350
TXCSES Menu Screens, C-832.2

A-1326.2.3 Medical Support Payments

Revision 15-4; Effective October 1, 2015

All Programs

When a court order is entered, it designates the amount of child support and/or medical support a parent receives on behalf of the children. Medical support is in the form of:

- health insurance, ordered in addition to child support; or
- a cash amount for the purpose of offsetting medical expenses.

TANF and SNAP

If the individual does not receive Medicaid and is responsible for paying medical expenses, the payments are considered a reimbursement and the policy for reimbursement in A-1332, Reimbursements, applies.

Cash medical support payments the individual receives and remits to Third Party Recovery (TPR) are not counted. Any of the cash medical support payment from the absent parent that the individual continues to keep counts as income.

Related Policy

Remitting Cash Medical Support Payments to the Third-Party Resources (TPR) Unit, A-861.5
TANF, A-1124
Reimbursements, A-1332

Medical Programs

Medical support payments are exempt.

If the individual has an open child support case with the OAG for children receiving Medicaid, the OAG processes medical support payments through an interface with HHSC/TPR, and the individual does not receive a direct payment. If an individual is not referred to the OAG for services and is receiving or begins receiving cash medical support payments, the individual is required to remit the payments to the TPR unit.

A-1326.3 Energy Assistance

Revision 15-4; Effective October 1, 2015

All Programs

Energy or utility payments and supplements are paid to or on behalf of the TANF, SNAP, and Medical Programs households from various governmental and private sources. The assistance may be in the form of cash, vendor, in-kind, and two-party check payments.

The chart below indicates when to exempt or count energy/utility assistance as TANF, SNAP, and Medical Programs income. **Note:** If an energy assistance payment is combined with other payments, only the energy assistance portion is exempt from income (if applicable).

Source	Type Payment	TANF	SNAP	Medical Programs
Federally-funded, state, or locally administered programs including CEAP, weatherization, Energy Crisis, and one-time payments for emergency repairs of a heating or cooling device (down payment and final payment)	• Vendor • In-kind • Two-party check • Cash	Exempt	Exempt	Exempt
Energy assistance received through HUD, U.S. Department of Agriculture's Rural Housing Service (RHS) or Farmer's Home Administration (FmHA)	• Vendor • In-kind • Two-party check • Cash	Exempt	Exempt	Exempt
State or local government-funded utility supplement or energy assistance payments (not federally-funded)	• Vendor • In-kind • Two-party check	Exempt	Exempt	Exempt
State or local government-funded utility supplement or energy assistance payments (not federally-funded) State or local government-funded utility supplement or energy assistance payments (not federally-funded)	• Cash	Exempt	Count	Exempt
Private nonprofit organization	• Vendor • In-kind • Two-party check	Exempt	Exempt	Exempt
Private nonprofit organization	• Cash	Count per A-1326.1, Cash Gifts and Contributions	Count per A-1326.1	Exempt
State or federal regulated utility company, a municipal utility company, or a supplier of home heating oil or gas	• Vendor • In-kind • Two-party check	Exempt	Exempt	Exempt
State or federal regulated utility company, a municipal utility company, or a supplier of home heating oil or gas	• Cash	Exempt	Count	Exempt

A-1326.4 Foster Care and Permanency Care Assistance (PCA) Payments

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Foster care or permanency care payments are exempt.

TANF

Do not include a person receiving foster care or permanency care payments in a TANF budget or certified group.

SNAP

If a foster parent or caregiver chooses to exclude a foster/PCA child/adult from the certified group:

- the foster care/PCA income for the foster/PCA child/adult who is excluded from the certified group is exempt; and
- all other income received by the excluded foster/PCA child/adult is exempt.

If a foster parent or caregiver chooses to include a foster/PCA child/adult in the certified group:

- the foster care/PCA income counts as unearned income for the foster/PCA child/adult;
- any other non-exempt income received by the foster/PCA child/adult is counted; and
- the foster care/PCA income under the foster/PCA child's/adult's name is budgeted for whom the payment is intended.

Related Policy

Who Is Not Included, A-222, No. 8

A-1326.5 In-Kind Income

Revision 15-4; Effective October 1, 2015

All Programs

In-kind income is exempt.

A-1326.6 Interest

Revision 17-1; Effective January 1, 2017

All Programs

Interest counts as unearned income unless specifically excluded.

Note: “Note interest” is one type of interest that is also counted as unearned income.

A-1326.7 Loans (Noneducational)

Revision 15-4; Effective October 1, 2015

All Programs

Financial assistance is considered a loan if:

- there is an understanding that the individual will repay the money; and
- the individual can reasonably explain how the loan will be repaid.

These loans are exempt from income. Contributions that are not considered loans must be considered as explained in A-1326.1, Cash Gifts and Contributions.

Note: See A-1234, Noneducational Loans, for policy on treating loans as a resource.

A-1326.8 Plan for Achieving Self-Sufficiency (PASS)

Revision 15-4; Effective October 1, 2015

All Programs

Any amount an SSI recipient deposits into a PASS account or uses toward completion of a PASS plan is exempt.

Note: If the PASS contribution is made from earned income, the advisor should enter the PASS income in the Employer – Employee Screen – Amount Totals – PASS Income. TIERS will deduct the PASS contribution from the gross earnings.

A PASS can be, but is not limited to, money that is:

- deposited into a savings account to purchase a vehicle for employment transportation;
- deposited into a savings account to start a new business; or
- used toward an educational program.

The PASS plan must be approved by the Social Security Administration.

The SSI recipient will receive a notice from SSA approving or disapproving the PASS plan. Advisors may use this notice as verification of the PASS plan.

Related Policy

Individual Development Accounts (IDAs), A-1231.3

A-1326.9 Pensions

Revision 15-4; Effective October 1, 2015

All Programs

A pension is any benefit derived from former employment (such as retirement benefits or a disability pension). A pension counts as unearned income.

A-1326.10 Trust Funds

Revision 15-4; Effective October 1, 2015

All Programs

Withdrawals or dividends that the household can receive from a trust fund (also referred to as trust payments) count as unearned income.

Related Policy

Trust Funds, A-1237

A-1326.11 Resettlement-Reception and Placement (R&P)

Revision 15-4; Effective October 1, 2015

All Programs

R&P payments are exempt.

A-1326.12 Refugee Cash Assistance (RCA)

Revision 15-4; Effective October 1, 2015

TANF

Individuals can receive RCA only if they are not eligible for TANF.

SNAP

RCA counts as income in the month received.

Medical Programs

RCA income is exempt.

A-1326.13 Match Grant

Revision 15-4; Effective October 1, 2015

TANF

Individuals can receive Match Grant only if they are not eligible for TANF.

SNAP

Follow the policy in A-1326.1, Cash Gifts and Contributions.

Medical Programs

Match Grant is exempt.

A-1326.14 Spousal Diversion and Dependent Allowance

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The portion of income from a spouse or parent in a nursing facility that is diverted to the family members living in the community counts as unearned income.

The spousal diversion and dependent allowance are determined by the Medicaid for the Elderly and People with Disabilities worker processing the application for nursing facility coverage. When nursing facility coverage is approved and disposed, TIERS will add this income in the community family member's approved Texas Works (TW) EDGs upon running Eligibility. Advisors do not make Data Collection entries for this income.

Medical Programs

Spousal diversion payments are exempt.

A-1326.15 Income Legally Obligated to Children in Department of Family and Protective Services (DFPS) Conservatorship

Revision 15-4; Effective October 1, 2015

All Programs

DFPS has systems in place to become a payee for legally obligated income the child received prior to DFPS taking conservatorship. This income may include (but is not limited to) child support, RSDI and SSI.

Foster care (FC) types of assistance (TOA) are identified in TIERS Inquiry as:

- Foster Care – Federal Match – With Cash,
- Foster Care – No Federal Match – With Cash,
- Foster Care – No Federal Match – No Cash, and
- Foster Care – Federal Match – No Cash.

Federal Match identifies Medicaid paid by matched funds from the federal government. **No Federal Match** identifies state-paid Medicaid only without matching federal funds. **With Cash** types of assistance (with or without federal match) indicate that the foster parent receives FC financial assistance for an FC child in addition to FC Medicaid. **No Cash** indicates the foster parent does not receive an FC financial payment but DFPS provides FC Medicaid only.

When reviewing inquiry systems such as WTPY/SOLQ and OAG, and DFPS is identified as the payee for the legally obligated income:

- The legally obligated income for an FC child who is receiving FC **With Cash** is not counted since DFPS keeps the legally obligated income.
- Legally obligated income for the FC child who receives FC **No Cash** is counted since DFPS sends the legally obligated income to the foster parent.
- The legally obligated income is counted when a child is placed back in the home of the individual from whom the child was removed. DFPS remains the conservator of the child receiving FC **No Cash**, and the legally obligated income is not forwarded. The individual

must inform the income source they are now the payee. If DFPS has not already provided the issuing agency this verification, that agency must verify with DFPS before changing the payee.
- FC and Adoption Assistance (AA) children placed in Texas from another state will receive a TOA **No Cash** from DFPS in Texas. However, the child may receive an FC or AA payment from the home state. When a child is receiving FC or AA in Texas and is from another state, the advisor must contact the home state to verify any countable legally obligated income.

Examples:

- A child receives SSI. DFPS removes the child from the custody of her mother. DFPS becomes the payee for the child's SSI.
- The child is placed with a foster parent. The child receives FC – Federal Match – With Cash. The foster parent chooses to include the child in the foster parent's SNAP household. The child is added to the foster parent's SNAP EDG. Since the child receives an FC payment, DFPS retains the child's SSI. The FC payment and SSI are not budgeted in the SNAP EDG because the FC payment is exempt income and DFPS keeps the SSI income.
- Months later, DFPS places the child with her great-aunt. The child now receives FC – Federal Match – No Cash. The child's great-aunt chooses to include the child in the great-aunt's SNAP household. The child is removed from the former foster parent's EDG and is added to her great-aunt's EDG and SNAP EDG. DFPS remains the payee for the child's SSI but sends it to her great-aunt. The SSI must be counted in the SNAP budget.
- Several months later, DFPS places the child back with her mother; however, DFPS retains conservatorship. The child continues to receive FC – Federal Match – No Cash. DFPS informs the SSA that the child now resides with her mother. The child's mother must inform SSA to have the child's SSI sent to her. The SSI must be counted in the SNAP budget.

Note: DFPS does not become the payee for children who receive adoption assistance.

A-1326.16 Reserved for Future Use

Revision 21-1; Effective January 1, 2021

A-1326.17 Alimony (Spousal Support) Received

Revision 21-2; Effective April 1, 2021

All Programs

Alimony payments, also referred to as spousal support, are payments received from a spouse or former spouse under a divorce or separation agreement.

SNAP and TANF

Count alimony received as unearned income for the person receiving the payment.

Medical Programs

If the divorce or separation agreements that include alimony payments were executed or last modified:

- on or before Dec. 31, 2018, count alimony received as unearned income for the person receiving the payment.
- after Dec. 31, 2018, do not count alimony received in the household's budget.

A-1326.18 Annuity

Revision 15-4; Effective October 1, 2015

All Programs

An annuity is a series of payments paid under a contract and made at regular intervals over a period of more than one full year. Payments can be either fixed (under which one receives a definite amount) or variable (not fixed). An individual can buy the contract alone or with the help of an employer.

Annuity payments are counted as unearned income.

A-1326.19 Capital Gains

Revision 15-4; Effective October 1, 2015

Capital gains are profit from the sale of property or of an investment when the sale price is higher than the initial purchase price (for example, profits from the sale of stocks, bonds, or from the sale of real estate).

TANF and SNAP

Capital gains are exempt.

Medical Programs

Capital gains are counted as unearned income.

A-1326.20 Housing Allowance

Revision 24-3; Effective July 1, 2024

SNAP and TANF

For specific types of housing allowances follow:

- military pay allotments and allowances policy; or
- government housing assistance policy.

If the employer garnishes or diverts a household member's wages and pays them to a third party to cover a housing expense like rent, the payments made to the third party are counted. However, if the employer pays the household's rent directly to the landlord and pays the household its regular wages, the rent payment is excluded from income.

Similarly, if the employer provides a housing allowance to an employee along with wages, exclude the value of the housing allowance from the employment income.

Count all other housing allowances as unearned income.

Medical Programs

Housing allowances provided as compensation for ordained, commissioned or licensed members of the clergy are excluded from MAGI budgeting if:

- the employing church or organization officially designates the payment as a housing allowance before it makes the payment;
- the total amount of the allowance does not exceed the total cost of renting or purchasing the home, including furnishings and utilities; and
- the amount of the allowance does not exceed the value of the services the person provides as a member of the clergy. If the housing allowance exceeds the housing costs or value of services provided, count the excess amount as earned income.

Housing allowances not addressed in this section, military pay allotments and allowances policy, or government housing assistance policy are counted as unearned income.

Related Policy

Military Pay Allotments and Allowances, A-1323.3
Government Housing Assistance, A-1324.4
Vendor Payments, A-1334

A-1326.21 Life Estate

Revision 15-4; Effective October 1, 2015

All Programs

Life estate income is income an individual receives from ownership of property that an individual only possesses ownership of for the duration of one's life (for example, rental income).

Life estate income is counted as unearned income.

A-1326.22 Jury Duty Pay

Revision 15-4; Effective October 1, 2015

Jury duty pay is taxable income received from jury duty as compensation.

TANF and SNAP

Jury duty pay is exempt.

Medical Programs

Jury duty pay is counted as unearned income.

A-1326.23 Court Awards

Revision 15-4; Effective October 1, 2015

Court awards are taxable money that an individual receives as the result of a lawsuit (for example, compensation for lost wages or punitive damages awards).

TANF and SNAP

Follow policy in A-1331, Lump-Sum Payments.

Medical Programs

Court awards income is counted as unearned income.

A-1326.24 Canceled Debt

Revision 15-4; Effective October 1, 2015

Canceled debts are debts that have been canceled, forgiven, or discharged, and the canceled amount is included as countable income on federal income tax returns (for example, loan foreclosures or canceled credit card debt).

TANF and SNAP

Canceled debt income is exempt.

Medical Programs

Canceled debt income is counted as unearned income.

A-1326.25 Achieving a Better Life Experience (ABLE) Accounts

Revision 17-1; Effective January 1, 2017

Achieving a Better Life Experience (ABLE) programs allow individuals (beneficiaries) who become blind or disabled before age 26 to establish tax-free savings accounts for the designated beneficiary's disability-related expenses.

All Programs

Contributions to an ABLE account from individuals other than the designated beneficiary, and any distributions from an ABLE account, are not considered income to the designated beneficiary.

Income of the designated beneficiary, or an individual whose income is considered when determining eligibility, that is deposited into an ABLE account, remains countable income when determining eligibility.

TANF and SNAP

Interest and dividends earned on an ABLE account are exempt.

Medical Programs

Interest and dividends earned on an ABLE account are countable as unearned income.

Related Policy

Achieving a Better Life Experience (ABLE) Accounts; A-1231.6

A-1326.26 School-Based Savings Accounts

Revision 17-1; Effective January 1, 2017

School-Based Savings Accounts are accounts set up by students or their parents at financial institutions that partner with school districts. The accounts are intended to help students save for higher education.

TANF and SNAP

Interest earned on School-Based Savings Accounts is exempt.

Medical Programs

Interest earned on School-Based Savings Accounts is countable as unearned income.

Related Policy

School-Based Savings Accounts, A-1231.7

A-1326.27 MyGoals Payments

Revision 18-1; Effective January 1, 2018

MyGoals payments are cash payments received by participants in the MyGoals for Employment Success demonstration project. The demonstration studies the impact of combining workforce development and financial payments on employment outcomes for recipients of the Housing and Urban Development, Section 8 Rental Assistance. Only residents within the jurisdiction of the Houston Housing Authority are selected to participate in the project.

All Programs

MyGoals payments are counted as cash contributions made by a private, nonprofit organization according to policy in A-1326.1, Cash Gifts and Contributions.

A-1326.28 Texas Lottery Commission

Revision 18-2; Effective April 1, 2018

All Programs

Count the **gross** amount of winnings as unearned income in the month received, regardless of the frequency of pay. The Data Broker information includes debt offset (recoupment) information.

Example: Applicant wins $1,000/month; however, there is a debt offset (recoupment) of $100 from the OAG for child support. The income budgeted will be $1,000.

Note: Some winners may elect to place their winnings in a trust fund.

Related Policy

Trust Funds, A-1326.10
Trust Funds, A-1237
Payments Exempt as a Resource While Being Considered Income, A-1243
Texas Lottery Commission, C-825.18

A-1330, Types of Payments

Body

Revision 04-3; Effective April 1, 2004

A—1331 Lump-Sum Payments

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Lump sums received once a year or less are exempt, unless specifically listed as income. These sums are considered as a resource in the month received, and the policy in A-1242, Lump-Sum Payments, applies.

Note: Retroactive or restored payments are considered to be lump-sum payments and count as a resource. Any portion that is ongoing income is separated from a lump-sum amount and counted as income.

Example: A person receives a lump-sum payment in the amount of $4,950 from the SSA in the month of March. Effective that same month, the person receives his first monthly RSDI payment of $950, which is included in the $4,950 lump-sum payment. Staff must budget the $950 RSDI payment beginning with the month of March as an ongoing payment and consider the $4,000 as a lump-sum payment.

A lump-sum payment counts as income in the month received if the individual gets it or expects to get it more often than once a year.

Exceptions: Contributions, gifts, and prizes count as unearned income in the month received, regardless of frequency of pay.

If a lump sum reimburses a household for burial, legal, medical bills or damaged/lost possessions, the countable amount of the lump sum is reduced by the amount earmarked for these items.

Federal tax refunds and EICs are exempt as income.

Medical Programs

All lump-sum payments are counted as income in the month they are received.

Note: Award prizes are considered lump-sum payments and are counted in the month they are received.

Related Policy

Cash Gifts and Contributions, A-1326.1
Federal Tax Refunds and Earned Income Tax Credits (EIC), A-1232.2

A-1332 Reimbursements

Revision 15-4; Effective October 1, 2015

TANF

A reimbursement (not to exceed the individual's expense) is exempt if it is provided specifically for a past or future expense:

- that is not included in HHSC's standard of need, or
- for medical needs that are not paid by Medicaid.

If the reimbursement exceeds the individual's expenses, any excess counts as unearned income. A reimbursement to exceed the individual's expenses is not considered unless the individual or provider indicates the amount is excessive.

Note: A reimbursement for future expenses is exempt only if the individual plans to use it as intended.

SNAP

A reimbursement (not to exceed the individual's expense) provided specifically for a past or future expense other than a normal living expense is exempt.

If the reimbursement exceeds the individual's expenses, any excess counts as unearned income. A reimbursement is not considered to exceed the individual's expenses unless the individual or provider indicates the amount is excessive.

Note: A reimbursement for future expenses is exempt only if the individual plans to use it as intended.

Medical Programs

A reimbursement is exempt. Reimbursements include private insurance payments.

A-1333 Third-Party Beneficiary

Revision 15-4; Effective October 1, 2015

All Programs

Money an individual receives that is intended and used for maintenance of a nonmember is exempt.

If an individual receives a single payment for more than one beneficiary, the amount actually used for the nonmember is excluded up to the nonmember's identifiable portion or prorated portion, if the portion is not identifiable.

A-1334 Vendor Payments

Revision 15-4; Effective October 1, 2015

All Programs

Payments that a person or organization outside the household makes directly to the individual's creditor or person providing the service are exempt.

TANF and SNAP

Exception: Money legally obligated to the household, but which the payer makes to a third party for a household expense is counted as income.

Example: In a SNAP EDG, the absent parent is court-ordered to pay $400 a month. Instead, the absent parent pays $150 cash support and also pays $300 of the custodial parent's rent directly to the landlord for a total of $450. The $150 cash and $250 of the vendor-paid rent counts as child support, since that portion is legally obligated to the individual. The $50 amount over the legally obligated child support of $400 is considered an exempt vendor payment.

Related Policy

Cash Gifts and Contributions, A-1326.1
Child Support, A-1326.2

A-1334.1 Vendor Payments from State and Local Government Funds

Revision 15-4; Effective October 1, 2015

SNAP

All vendor payments made for a household with a migrant farm worker in the workstream that are paid with state or local government funds are exempt.

Vendor payments paid to other people with state or local government funds are counted unless the payment provides assistance for:

- medical expenses,
- child care, or
- expenses related to natural disasters (for example, fires or floods).

Note: Vendor payments paid with federal funds (for example, federally funded housing assistance) are exempt. Policy in A-1326.3, Energy Assistance, applies.

TANF and Medical Programs

Vendor payments from state and local government funds are exempt.

A-1340, Income Limits

Body

Revision 08-1; Effective January 1, 2008

A-1341 Income Limits and Eligibility Tests

Revision 21-3; Effective July 1, 2021

TANF

There are two eligibility tests for TANF.

Budgetary Needs Test

The budgetary needs test is the first eligibility test for the household. It applies to all households who have not received TANF in the last four months (in Texas or another state).

If an unmet need of less than 50 cents remains, the household is ineligible.

Recognizable Needs Test

The recognizable needs test is the final eligibility test for the household. This test applies to all applicants and certified households.

The recognizable needs test has two parts. Applicant households (those subject to the budgetary needs test) must pass both Part A and Part B. All other households must pass only Part B.

If an unmet need of one cent or more remains, the household is eligible.

Needs Tests Instructions

Include all countable earned and unearned income. Follow the steps below:

1. Total the gross earned and unearned income for each person.
2. Add applied income amount. Applied income is the countable amount of income after allowing deductions for tax dependents, child support, alimony, and people a legal parent is legally obligated to support.
3. Subtract the child support disregard, if applicable.
4. Subtract the standard work-related expense (not to exceed the household member's monthly earned income) for each qualifying member with countable earnings.
5. Subtract each member's allowable costs for dependent care (up to the maximum).
6. Subtract any child support expense.
7. Compare the net income to the budgetary needs amount. If the net income or unmet need is 50 cents or more, the household passes the budgetary needs test.

Note: If there is a diversion amount and someone other than the person with diversions has count income (or two household members with joint diversions both have countable income), each member's income or earned income deductions are computed separately until the **actual** amount allowed to be diverted from each person's income is subtracted. Then the total net incomes are combined.

When two members have joint diversions, any amount of the diversion that exceeds one member's income can be diverted from the other member's income using the steps below:

1. Subtract 1/3 of the net income for applicants with earned income who have not been active TANF in the last four months.
2. Subtract 90 percent of the remaining earnings (up to a cap of $1,400). Allow this deduction for each employed household member who is eligible for it. The person can receive this deduction for four months in a 12-month period. The four months do not have to be consecutive. **Note:** Do not count a month in which a full-family sanction is imposed as one of the 90 percent earned income deduction (EID) months.

Note: If there is a diversion amount and someone other than the person with diversions has countable income (or two members with joint diversions both have countable income), each member's income and earned income deductions are computed separately until after subtracting the **actual** amount allowed to be diverted from each person's income. Then the adjusted gross incomes are combined.

When two members have joint diversions, any amount of the diversion that exceeds one member's income can then be diverted from the other member's income.

For each household member with earnings, the deductions cannot exceed the person's total income. This also applies when there is more than one household member with earnings, diverted income or both.

The adjusted income should be compared to the recognizable needs amount. If the adjusted income is one cent or more, the household passes the recognizable needs test.

The adjusted income is subtracted from the maximum grant amount to determine the benefit amount.

Related Policy

Child Support Deductions, A-1421
$75 Disregard Deduction, A-1422
Dependent Care Deduction, A-1423

Diversions, Alimony, and Payments to Dependents Outside the Home, A-1424
Work-Related Expense ($120 and 20%), A-1425.1
1/3 Disregard for Applicants, A-1425.2
90% Earned Income Deduction, A-1425.3
Income Limits, C-111

SNAP

There are two eligibility tests for SNAP.

Gross Income Test

Gross income is the total countable income. This test applies to all households except those:

- with a member who is elderly or has a disability; or
- that are categorically eligible.

To be considered categorically eligible, all household members must be approved for TANF or SSI, or a combination of TANF and SSI, or the household must meet resource criteria and have gross income below or equal to 165 percent Federal Poverty Level (FPL) for its size.

A household subject to the gross income test is ineligible if unrounded gross income exceeds the limit by one cent or more.

Note: For households with a deductible farm loss, the loss is subtracted before applying the gross income test.

Related Policy

Households with Elderly Members or Members with a Disability, B-430

Net Income Test

Net income is the gross income minus allowable deductions. This test applies to all households, except categorically eligible households.

Note: The net income test applies to a household with a member who is elderly or has a disability if the household's gross income exceeds 165 percent FPL and the household does not meet categorically eligible requirements.

If a household's rounded income exceeds the net income limits, the household is ineligible. Fifty cents or more is rounded up and 49 cents or less is rounded down. The EDG is denied if net income results in zero allotment for the initial and ongoing months.

TIERS will assign the appropriate income test at Eligibility Summary after running Eligibility Determination Benefit Calculation (EDBC).

Related Policy

Benefits, A-2322
Maximum Income Limits, C-121

Medical Programs

For Medical Programs, Modified Adjusted Gross Income (MAGI) financial eligibility is determined by comparing the applicable program income limit and the MAGI household income calculated using **Step 1** through **Step 5** below.

Follow the five steps below in the specified order for **each person applying for benefits** to determine MAGI financial eligibility for each person.

Step 1 — Determine MAGI Household Composition

The MAGI household composition for the person will be used to complete Steps 2, 3, 4, and 5.

Step 2 — Determine MAGI Individual Income

Identify and list all income, expenses, and overpayments for each person in the MAGI household.

Form H1042, Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP, is used for each person included in the person's MAGI household composition to list and calculate:

- earned income, excluding any pretax contributions;
- unearned income;
- self-employment income;
- American Indian/Alaska Natives (AI/AN) disbursement;

- overpayments; and
- expenses.

Step 3 — Determine Whether Any Exemptions Apply to MAGI Household Income

If a person meets one of the following exceptions for the taxable year in which Medicaid or Children's Health Insurance Program (CHIP) eligibility is requested, their MAGI individual income is not included when calculating MAGI household income (as explained in **Step 4**).

Exception 1:

A person is a child (natural, adopted or step), regardless of age, who is:

- included in the MAGI household composition of a parent or whose MAGI household composition includes a parent; and
- not expected to be required to file a federal income tax return since the child's monthly income is below the monthly Internal Revenue Service (IRS) income threshold.

Exception 2:

A person is a tax dependent who is:

- included in the MAGI household composition of the taxpayer claiming them as a tax dependent; and
- not expected to be required to file a federal income tax return since the tax dependent's monthly income is below the monthly IRS income threshold.

If a person meets the criteria for Exception 1 or 2 and does not have any income, it is not necessary to determine whether the person is expected to be required to file an income tax return because there is no income to compare with the IRS income threshold. Move to **Step 4** at this point.

Note: Even if a person's tax status is "non-taxpayer/non-tax dependent," the person may be "expected to be required to file" a federal income tax return based on the IRS threshold amounts.

For a person who is expected to be required to file a federal income tax return, all MAGI Individual Income from Step 2 counts in every household composition in which that person is included.

If a child meets **Exception** 1:

- their income is excluded from the MAGI household income of every applicant or recipient whose MAGI household composition includes that child; and
- the child's income is exempt from their own MAGI household income.

If a tax dependent meets **Exception** 2:

- the tax dependent's income is excluded from the MAGI household income of the taxpayer who plans to claim that person on a federal income tax return for the taxable year in which the taxpayer is requesting Medicaid or CHIP eligibility; and
- this tax dependent's MAGI Individual Income counts in their own MAGI household income and counts in the MAGI household income of everyone else in whose MAGI household they are included.

If a person meets the criteria for both exceptions (a child (regardless of age) included in the MAGI household composition of a parent **and** a tax dependent included in the MAGI household composition of the taxpayer), Exception 1 applies. Exception 1 is more beneficial for the child because the child's income would then be exempt from the child's MAGI Individual Income.

Example: A child (regardless of age) lives with her mother, has no income, and her mother expects to claim the child on her federal income tax return. The child would meet Exception 1 and Exception 2. For the purposes of exempting the child's income, the child (regardless of age) is considered a child who is included in the MAGI household composition of a parent whose MAGI group includes a parent (Exception 1). Because the child has no income to exempt, there is no need to compare her income to the tax thresholds. If the child did have income under the threshold, it would be more beneficial to allow her Exception 1 so that her income would not be counted on her own MAGI household income.

Example: Grandma Mary and Grandpa John expect to file taxes jointly and claim their three grandchildren, Sally, 8, Lucy, 12 and Mike, 14, as tax dependents. Grandma Mary and Grandpa John have **not** adopted their grandchildren. Grandma Mary applies for medical assistance for her grandchildren but does **not** apply for medical assistance for herself or Grandpa John.

Sally, Lucy, and Mike each receive $1500 a month in Social Security survivor benefits (SSB). The children meet a tax dependent exception because they are claimed as a tax dependent by a taxpayer who is not their spouse or parent. Their MAGI household compositions are determined using the non-taxpayer and non-tax dependent rules.

The MAGI household for each child includes the three siblings (Sally, Lucy and Mike) and the survivor benefits count in each child's own MAGI household income and in the MAGI household income of their siblings. If Grandma Mary and Grandpa John had applied for medical assistance, the children's survivor benefits would **NOT** count in their MAGI household income.

Step 4 — Calculate MAGI Household Income

First, the MAGI Individual Income for each person included in the applicant's or recipient's MAGI household composition is calculated by:

- adding earned income, unearned income, self-employment income, and AI/AN disbursements (if AI/AN status is not verified per policy or the income source is not verified);
- subtracting overpayments; and
- subtracting expenses.

Income and Expenses	Person 1	Person 2	Person 3	Person 4
Total earned/unearned income				
Add	+	+	+	+
Total self-employment Income				
Add	+	+	+	+
Total AI/AN disbursement				
Subtract	-	-	-	-
Total recoupment of overpayments				
Subtract	-	-	-	-
Total expenses				
Equals	=	=	=	=
MAGI Individual Income				

Second, the MAGI Individual Income for all people included in the applicant's or recipient's MAGI household composition must be totaled. Anyone's income (as applicable) based on Exceptions 1 and 2 from Step 3 is exempt.

Add MAGI Individual Income + + +=

Third, the standard MAGI income disregard, by MAGI household size, must be subtracted from the sum of the MAGI Individual Incomes to get the MAGI household income. The standard MAGI disregard is an income disregard equal to five percentage points of the FPL. It is a standard amount based on the applicable household size across all Medical Programs that use MAGI rules to determine income.

Ex. Sum of MAGI Individual Incomes *subtract* **Standard MAGI Disregard** *equals* **MAGI Household Income**

Note: The standard MAGI income disregard is updated annually based on the annual updates to the FPL.

Step 5 — Determine MAGI Financial Eligibility

The person's eligibility is determined by comparing whether the applicant's or recipient's MAGI household income is less than or equal to the income limit of the applicable program based on FPL and MAGI household size.

Steps 1 to 5 must be repeated for each person applying for Medical Programs.

Related Policy

Medical Programs, A-240
Who Is Included, A-241.1
Verification Requirements, A-1370
Income Limits, C-131
Standard MAGI Income Disregard, C-131.4
IRS Monthly Income Thresholds, C-131.5
Guidelines for Providing Retroactive Coverage for Children and Medical Programs, C-1114

A-1341.1 Grant Amount

Revision 24-4; Effective Oct. 1, 2024

TANF

The TANF grant amount is the amount of the monthly benefit. The TANF grant is approximately 17 percent of the Federal Poverty Level (FPL). The federal government periodically adjusts the FPL.

After the household passes the recognizable needs test, the recommended grant amount is calculated. Subtract the household's adjusted gross income, rounded down to the nearest dollar, from the maximum grant amount allowed for the household's size and composition.

The minimum grant amount is $10. The household is eligible to receive the minimum grant if the recommended grant amount is less than $10.

Benefits of less than $10 are issued only for:

- supplemental payments; and
- payments made after processing a recoupment.

Related Policy

Income Limits, C-111

A-1350, Calculating Household Income

Body

Revision 15-4; Effective October 1, 2015

All Programs

A household's income is computed to determine eligibility and benefit amount. Household income is computed by using:

- actual income (income that was already received), or
- projected income amounts (not received but expected).

Notes:

- Both actual income amounts and projected income amounts for the current month are used to determine eligibility and benefits.
- For households paid on a monthly or semi-monthly basis, income is counted for the month it is intended if the household receives:
  - the income in a different month because of a change in the mailing cycle or pay date; or
  - an additional or missed payment because of weekends or holidays.

Exception: A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income, may be used when using the TWC wage record to calculate income.

TANF

If a child lives with a married relative (not a parent) who wants to be the caretaker, eligibility and benefits are determined using:

- normal budgeting for the applicant's income, and
- stepparent budgeting for the income of the applicant's spouse.

Medical Programs

See A-1341, Income Limits and Eligibility Tests, for Medical Programs.

A—1351 Irregular and Unpredictable Income

Revision 15-4; Effective October 1, 2015

SNAP

Income that is irregular and unpredictable is exempt if both of the following conditions apply:

- The anticipated income will be less than or equal to $30 per household in a federal fiscal quarter; and
- The individual receives the income too infrequently or too irregularly to reasonably anticipate it. "Reasonably anticipate" means the individual knows:
  - who the income will come from,
  - in what month it will be received, and
  - how much it will be.

A—1352 Terminated Income

Revision 15-4; Effective October 1, 2015

All Programs

Terminated income counts in the month received. Actual income must be used and conversion factors are not used if terminated income is less than a full month's income.

Income is terminated if it will not be received in the next usual payment cycle.

Income is not terminated if:

- someone changes jobs while working for the same employer;
- an employee of a temporary agency is temporarily not assigned;
- a self-employed person changes contracts or has different customers without having a break in normal income cycle; or
- someone receives regular contributions, but the contributions are from different sources.

A—1353 How to Convert Income to Monthly Amounts

Revision 15-4; Effective October 1, 2015

All Programs

If actual or projected income is not received monthly, the income should be converted to monthly amounts using one of the following methods:

- Divide yearly income by 12.
- Multiply weekly income by 4.33.
- Add amounts received twice a month (semi-monthly).
- Multiply amounts received every other week by 2.17.

Note: A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income, can be used for converting TWC wages.

A—1353.1 Converting New Semi-Monthly Income

Revision 15-4; Effective October 1, 2015

All Programs

The following procedures should be followed if an individual has a new source of semi-monthly income and has not received enough checks to reliably project the income:

1. Determine the estimated number of hours the individual will work per week.
2. Estimate weekly gross income by multiplying the weekly estimated hours by the hourly wage.
3. Determine the monthly projected gross income by multiplying the estimated weekly gross income by 4.33.
4. To determine the semi-monthly income amount to enter on the income screen, divide monthly gross income by two.

A—1354 How to Budget Actual Income

Revision 15-4; Effective October 1, 2015

All Programs

Actual income is income that has already been received. Actual income is budgeted by:

- determining the actual income received in a past month; and
- converting the averaged amount to a monthly amount. See A-1353, How to Convert Income to Monthly Amounts, for instructions on how to convert income to a monthly amount.

Actual income should not be converted when:

- determining eligibility for three months prior Medicaid; or
- the income received from a new or terminated source is less than a full month's income.

Note: A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income, can be used for budgeting TWC wages.

A—1355 How to Project Income

Revision 20-4 Effective October 1, 2020

All Programs

Projected income is income a person has not received, but expects to get. To project income:

1. Evaluate the household's income and circumstances with the person.
2. Budget income in the month the person anticipates getting it. Budget:

- actual income received as of the interview date (or the date the information was requested); and
- income that can be reasonably anticipated for pay periods after the interview or information request date. "Reasonably anticipated" means the person knows:
  - the source of the income;
  - in what month the person will get the income; and
  - what amount of income the person will get.

3. When a person does not get income monthly but anticipates getting a full month's income, convert it to a monthly amount using conversion factors.
4. When a person gets an additional payment outside the regular payment cycle, convert the regular payments and add the additional payment to the converted amount.

Note: To determine the date income can be reasonably anticipated, use factors specific to the source of income, distance it travels through the mail, electronic transfers, weekends and holidays.

For people getting unemployment insurance benefits, determine the availability of funds in the account by adding one business day to the payment date listed on the Texas Workforce Commission Inquiry Benefit Payment screen.

For child support payments disbursed through the Texas debit card, follow policy in A-1326.2.1, Counting Child Support.

Fluctuating Income

If income is ongoing, but the amounts fluctuate, it is best to anticipate income by averaging income from past pay periods. When using this method:

- Verify at least two pay amounts in the time period beginning 45 days before the file date through the interview date (or the date the EDG is being processed if an interview is not required).
- Continue to enter amounts for all pay periods in the required budget months, using either year-to-date (YTD) amounts or the average amount of received payments for any unverified pay dates.

If the household states the payments are representative of current income, use YTD amounts, if available, for missing pay periods and use the average amount of verified payments for other unverified pay periods in all budget months. Use more than two pay amounts if they are available, but do not pend to require more than two pay amounts when a person says the pay amounts are representative of current income and the statement is not questionable.

Exception: For Children's Medicaid, see policy in A-1371, Verification Sources.

Use a different method to anticipate income when someone has a new job, seasonal fluctuations occur, or expected changes (such as changes in work hours or rate of pay) cause too many past amounts to be unrepresentative of current income.

Different methods of anticipating future income are:

- asking the employer for an estimate;
- using less than the required number of pay periods when they are not all available;
- multiplying anticipated hours by the rate of pay; or
- other methods.

Document the reason and calculations for the method used.

Example: When an applicant has paychecks, use the YTD amounts to find any missing pay amounts, if possible. In this situation, the gross pay on the checks is representative of current income.

Pay Date	Gross Pay Amount	YTD
05/11	(missing paycheck)	(missing paycheck)
05/25	$265.50	$4,675.93
06/09	(missing paycheck)	(missing paycheck)
06/23	$262.84	$5,199.18

You must have the checks before and after the missing paycheck. Take the YTD gross amount of the check prior to the missing paycheck and subtract it from the check received directly after the missing paycheck.

$5,199.18 YTD of check dated 06/23
- $4,675.93 YTD of check dated 05/25
= $523.25 Difference of the YTD amounts

Then subtract the gross pay amount of the paycheck received after the missing paycheck from the difference of the YTD amounts.

$523.25 Difference of the YTD amounts
- $262.84 Gross pay amount of check dated 06/23
= $260.41 Gross pay amount of check dated 06/09

Then add the three amounts together and divide by three to determine the average for the other missing pay period.

$265.50 Gross amount of 05/25
+ $260.41 Gross amount of 06/09
+ $262.84 Gross amount of 06/23
= $788.75 ÷ 3 Total of three checks then divide by three
= $262.92 Average to use for check dated 05/11

Non-Fluctuating Income

All Programs (except TP 43, TP 44 and TP 48)

- Verify that a source of income (earned or unearned) does not fluctuate.
- Verify the frequency of the payment.
- Require gross pay from only one payment received in the 45 days before the file date through the interview date if the person states the frequency and gross pay have not changed. Use this income amount for unverified pay periods in all budget months.

Exception: Do not apply this policy to sources of income that involve fluctuations in pay due to overtime, tips, commission, bonuses, hourly wages, etc.

Examples:

- At initial certification, a person gave proof he is paid a weekly gross salary of $400 with no fluctuations. He is now being interviewed for a SNAP redetermination and has one pay stub dated within 45 days of the application file date showing earnings of $400 for the week. He states there have been no changes in his weekly gross pay or the pay frequency. One pay stub is acceptable proof in this example, because the pay amount and frequency were previously verified and the person stated the pay amount and frequency have not changed.
- Another person is being interviewed for a SNAP application and has one pay stub dated within 45 days of the application file date. She states she is paid a weekly gross salary of $500 and that her pay does not fluctuate. The employer verifies the pay frequency and that the gross amount does not fluctuate. Accept the single pay stub as proof of gross pay and do not pend for other pay stubs unless the income is otherwise questionable.

A—1355.1 Budgeting Options for SNAP Households

Revision 15-4; Effective October 1, 2015

SNAP

If income is received more than once a month, monthly converted amounts are used to compute the monthly average. If the monthly income fluctuates, the household may choose to average its monthly income over the entire certification period. The advisor must determine the household's eligibility and benefits based on the average income.

Exception: The income of destitute households must not be averaged over the certification period.

A—1355.2 How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income

Revision 21-2; Effective April 1, 2021

All Programs

The quarterly wage records displayed on TWC inquiry reflect wages earned in the quarter ending as late as one month before the current calendar month. However, because the wage records are updated quarterly, wages may be further in the past. TWC quarters are displayed as a number corresponding to the quarter of the year in which the wages were earned, as illustrated below:

- The first quarter is January through March and is displayed as a **1** and the corresponding year.
- The second quarter is April through June and is displayed as a **2** and the corresponding year.
- The third quarter is July through September and is displayed as a **3** and the corresponding year.
- The fourth quarter is October through December and is displayed as a **4** and the corresponding year.

Use the gross monthly amount determined from using TWC wage records, when applicable, in all of the following budget months:

- application; and
- ongoing.

Note: A-831.3, Income Computation, may be used when determining the budget for prior Medicaid months.

Use the following chart to determine payment amounts when using TWC wage records to budget earned income.

Did the person receive three full months of income in this quarter?	then use one of the following calculations:
Yes	• **Weekly** – Divide the quarterly amount by the number of pay periods in the selected quarter. • **Bi-Weekly** – Divide the quarterly amount by the number of pay periods in the selected quarter. • **Semi-Monthly** – Divide the quarterly amount by 3 and then divide the monthly amount by 2. • **Monthly** – Divide the quarterly amount by 3. • **Quarterly** – Use the quarterly amount.
No	• **Weekly** – Divide the quarterly amount by 3 and then divide the monthly amount by 4.33. • **Bi-Weekly** – Divide the quarterly amount by 3 and then divide the monthly amount by 2.17. • **Semi-Monthly** – Divide the quarterly amount by 3 and then divide the monthly amount by 2. • **Monthly** – Divide the quarterly amount by 3. • **Quarterly** – Use the quarterly amount.

Note: TIERS uses the calculations in the chart above to derive the Calculated Payment value on the "TWC Inquiry" section of the **Employment Payments** screen.

Before using TWC quarterly wage information as a verification source for earned income, use the preferred methods of verification for the applicable program.

TANF and SNAP

The following sources continue to be the preferred methods of wage verification if they are available without having to pend the EDG to obtain them:

- the most recent consecutive check stub(s); or
- Form H1028, Employment Verification.

If these preferred sources of verification are not available during the interview, or when processed if no interview is required, and it would be necessary to pend for wage verification, the TWC quarterly wage information should be used as verification as explained below.

Using TWC Quarterly Wage Information as Verification of Earned Income

	Yes– Continue	**No** – Pend for other wage verification
1. Did the person receive pay for all pay periods in all months of the most recent quarter posted from the current employer, and none of the months includes leave without pay or a change in work hours from full-time to part-time?		
2. Is the person still employed by the employer listed on the most recent TWC quarter?	**Yes– Continue**	**No** – Pend for other wage verification

3. Is the person's pay rate the same now as it was for each month of the most recent quarter reported to TWC?	**Yes– Continue**	**No** – Pend for other wage verification
4. After discussion with the person, do they agree that the result is representative of anticipated future gross wages per pay period?	**Yes – Use TWC wage record as verification**	**No** – Pend for other wage verification

Note: Convert the income to the frequency the person receives the income before discussing with them whether the earnings shown in TWC records are representative of current and/or future earnings.

Note: Verify tip income not included on a person's wage statement by obtaining a signed and dated statement from the person.

Medical Programs

If the person's reported income is not reasonably compatible with electronic data sources, pend for verification of earned income and determine whether the TWC quarterly wage information can be used as verification of earnings. The TWC wage record may be used as a verification source if both of the following conditions are met:

- the current employer listed on the Medicaid application or redetermination form matches the employer listed on the most recent TWC wage record; and
- all household members for whom the household is applying are eligible based on the TWC quarterly wage information.

Convert the quarterly wage data to monthly income amounts, as described above.

If the income reported on the application or redetermination form makes the household ineligible, do not require the verification of earnings. If a member is ineligible based on the TWC data but appears eligible based on wages reported on the application form, request other income verification.

Note: If the TWC quarterly wage data is older than the verification used in the current SNAP budget, use the SNAP budget to determine eligibility for Medicaid applications or renewals.

Related Policy

Income Computation, A-831.3
Verification Requirements, A-1370
Verification Sources, A-1371

A—1356 Income Received Less Often Than Monthly

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

If income is received less often than monthly, the income is prorated over the period covered.

SNAP

If income is received less often than monthly, the income:

- counts in the month received, or
- is prorated over the period the income is intended to cover (at the individual's option).

Exception: Income of destitute farm workers is not prorated.

A—1357 Computing Benefits by EDG Action Type

Revision 14-1; Effective January 1, 2014

All Programs

Action Type	Budgeting
Application	• For past months, use the actual amounts for the entire month and use the appropriate conversion factor. For three months prior, use the actual amounts received for the entire month but do not use a conversion factor. • For the interview month, use a combination of actual amounts (amounts that have already been received) and projected amounts for amounts that have not been received yet, based on policy in A-1355, How to Project Income. • For future months, project amounts. • For TWC, see A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income.
Untimely redetermination – interview after the last benefit month	• For past months, use the actual amounts for the entire month and use the appropriate conversion factor. For three months prior, use the actual amounts received for the entire month but do not use a conversion factor. • For the interview month, use a combination of actual amounts (amounts that have already been received) and projected amounts for amounts that have not been received yet, based on policy in A-1355, How to Project Income. • For future months, project amounts. • For TWC, see A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income.
Untimely redetermination – interview during the last benefit month	• For the new certification period, project amounts. • For TWC, see A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income.
Timely redetermination	• For the new certification period, project amounts. • For TWC, see A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income.
Changes	Project amounts.
Claims/Restored benefits	Use actual amounts.

A—1358 How to Budget Expenses

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Only household expenses expected during the certification period should be considered to determine eligibility and benefits.

Expenses should be projected using the most recent month's bills and any anticipated increases or decreases. The household may choose to average expenses if they are anticipated to fluctuate or occur less often than monthly.

If the individual is billed for expenses weekly, biweekly or semi-monthly, the income conversion factors found in A-1353, How to Convert Income to Monthly Amounts, may be used to determine monthly expenses.

Medical Programs

Budgeting MAGI expenses is explained in A-1411, Rules That Apply to Deductions, Medical Programs.

A—1359 How to Determine Spend Down

Revision 05-1; Effective January 1, 2005

A—1359.1 Determining Eligibility/Spend Down for the Application and Following Months

Revision 15-4; Effective October 1, 2015

TP 56 and TP 32

Children and pregnant women with unpaid medical bills must first be determined ineligible for Medicaid or CHIP before being considered for TP 56 or TP 32.

TP 56 and TP 32 use MAGI rules to determine financial eligibility as explained in A-1341, Income Limits and Eligibility Tests, Medical Programs, with the following exception.

Exception: When calculating MAGI household income in **Step 4** for TP 56 and TP 32, the only income that is included for the applicant or recipient is income from the following individuals, if these individuals are in the applicant's or recipient's MAGI household composition:

- The applicant;
- The applicant's parents, if the applicant is under age 19; and
- The applicant's spouse (if applicable).

Informing individuals about spend down is explained in A-1532.1, Spend Down EDGs.

A—1359.2 Determining Eligibility/Spend Down for Three Months Prior

Revision 15-4; Effective October 1, 2015

TP 56 and TP 32

Children and pregnant women must be determined ineligible for Medicaid or CHIP before being considered for TP 56 or TP 32 coverage for three months prior to the application month and must have:

- unpaid medical bills during the prior month(s), or
- received Medicaid services from the Texas Department of State Health Services during the prior months.

Advisors must determine financial eligibility for TP 56 and TP 32 for the three months prior to the application month by following the MAGI rules as explained in A-1359.1, Determining Eligibility/Spend Down for the Application and Following Months.

Children and pregnant women may be determined eligible for TP 56 or TP 32 coverage for any month in the three months prior to the application month. Advisors must notify the applicant of the eligibility determination for each month.

A—1359.3 Corrections to a TP 56 EDG

Revision 15-4; Effective October 1, 2015

TP 56

The following procedures are used to notify the Medically Needy Clearinghouse (MNC) when:

- a correction must be made to a TP 56 EDG with spend down; and
- the Clearinghouse has not processed the EDG.

The claims administrator at 1-800-252-8263 is the contact entity to speak with someone concerning a Medicaid EDG with spend down. Advisors should have access to the following information concerning the EDG before calling:

- EDG name;
- EDG number;
- advisor's name;
- advisor's employee number and mail code;
- advisor's telephone number; and
- all information about the change.

A-1360, Determining Countable Income in Special Household Situations

Body

Revision 15-4; Effective October 1, 2015

A-1361 Alien Sponsor's Income

Revision 21-1; Effective January 1, 2021

TANF, SNAP, TP 07, TP 08, TP 20, TP 40, TP 43, TP 44, TP 48, TP 56, TP 70, TA 84 and TA 85

Count the income of the alien's sponsor and the sponsor's spouse (if the spouse also signed an affidavit of support).

Do not apply this policy to sponsored aliens who:

- are children under 18;
- are ineligible for benefits. Examples include those who are disqualified from getting benefits or those considered non-members, such as students who do not meet SNAP student eligibility criteria);
- have become naturalized U.S. citizens;
- have 40 quarters of work history or can receive credit for 40 quarters of work;
- have a deceased sponsor;
- have a sponsor who is a member of the alien's household or Modified Adjusted Gross Income (MAGI) household composition;
- are refugees, parolees, asylum grantees, Amerasians, victims of severe trafficking or Cuban or Haitian entrants;
- are indigent. Use this exception only if the alien does not meet one of the other exceptions noted in this list. Deem only the amount the sponsor will give the alien for a 12-month period starting the month of the indigence determination. Each determination is renewable for an additional 12-month period;
- are battered alien spouses of U.S. citizens or of legal permanent residents, children of battered aliens, or parents of battered children, if:
    - HHSC determines the battery is substantially related to the need for benefits; and
    - the battered person does not live with the batterer.

Do not deem the sponsor's income for 12 months for battered aliens, starting the month the alien is certified for any benefit. Do not assign a new 12-month period if the alien reapplies after a denial of benefits. After the first 12 months, continue exempting the sponsor's income from deeming if:

- a court or the U.S. Citizenship and Immigration Services (USCIS) recognize the battery;
- HHSC determines the battery has a substantial connection to the need for benefits; and
- the alien does not live with the batterer.

Use the following list of circumstances as a guide in making the substantial connection between the battery and the need for benefits. Determine if the battered alien needs the benefits:

- to become self-sufficient after leaving the abuser;
- to escape the abuser, the community or both in which the abuser lives;
- to ensure the battered alien's safety;
- to replace financial support lost as a result of the separation from the abuser;
- because of the loss of a job or reduced earnings resulting from the battery or cruelty;
- because the battered alien needs medical attention or mental health counseling or now has a disability due to the battery;
- because the battered alien lost the home, and the separation from the abuser jeopardizes the battered alien's ability to care for the children;
- to reduce nutritional risks;
- to get medical care for a pregnancy resulting from sexual assault or abuse; or
- to replace medical coverage or health care services.

Each time a determination of indigence is made, send a memo with the name, address, Social Security number, and date of birth of both the indigent alien and the indigent alien's sponsor, to the Access and Eligibility Services (AES) Program Policy mailbox. Before sending the memo, explain to the sponsored alien that federal regulations require state offices to report the sponsor to the USCIS for failure to give support as required on the sponsor affidavit. Allow the sponsored alien to choose to have the sponsor's income deemed if the alien does not want state office to send this report.

TANF, TP 07, TP 08, TP 20, TP 40, TP 43, TP 44, TP 48, TP 56, TP 70, TA 84 and TA 85

This policy does not apply to:

- sponsored aliens whose sponsors get TANF or SSI; or
- the dependent child of a sponsor or sponsor's spouse.

TP 43, TP 44 and TP 48

When determining eligibility for a child whose parent is a sponsored alien and a required member of the budget group, do not count the income of the parent's sponsor.

SNAP

This policy does not apply to:

- sponsored aliens whose sponsors get SNAP as a member of the same household; or
- organizations or groups that sponsor aliens.

A-1361.1 Budgeting the Individual Sponsor's Income

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Consider all of the sponsor's gross countable income as available to the alien's household, minus only the following deductions:

- The lesser of:
  - 20 percent of the total gross monthly earned income (including net self-employment earned income); or
  - $175.
- The budgetary needs (100 percent) figure of a one- or two-parent caretaker TANF EDG for the sponsor's family size. For Medical Programs, use the appropriate income limits figure for the sponsor's family size. Include all members of the household whom the sponsor claims or could claim as tax dependents. **Note:** For TANF, see A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, to determine:
  - whether to use the needs allowance of an adult or a child; or
  - the needs amount for more than two adults.
- The total amount the sponsor pays to a claimed tax dependent living outside the home.
- Total alimony or child support the sponsor pays to persons living outside the home.

Count the remaining amount as unearned income for the alien.

SNAP

Consider all of the sponsor's gross countable income as available to the alien's household, minus only the following deductions:

- 20 percent of the sponsor's total monthly gross earned income (including net self-employment earned income).
- An amount equal to the gross income limit for a household including the sponsor, the spouse, and any others claimed or who could be claimed as tax dependents (even if living outside the home). Do not include people who live with the sponsor but cannot be claimed as tax dependents.

Compare the computed countable income with the actual contributions that the alien received from the sponsor and spouse.

Budget the higher of the two amounts as unearned income to determine the alien's eligibility and benefits.

A-1361.2 Prorating the Sponsor's Income

Revision 01-7; Effective October 1, 2001

All Programs

If several aliens are sponsored, prorate the remaining income evenly among all the aliens who apply for or receive benefits.

A-1361.3 Budgeting the Organization Sponsor's Income

Revision 01-7; Effective October 1, 2001

TANF

An alien sponsored by an organization is not eligible for TANF unless the alien:

- can prove the organization no longer exists; or
- provides income and resource information for the organization.

If the alien provides income and resource information, contact Texas Works Policy Section, state office, for special budgeting procedures.

A-1362 Disqualified Members

Revision 16-2; Effective April 1, 2016

TANF

The income of a disqualified legal parent, including a disqualified second parent, is counted. Procedures in A-1362.1, TANF — Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits, or A-1362.2, TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction, apply.

The income of a disqualified child who is a required member of the certified group is counted. Procedures in A-1362.2 apply.

The income of other noncertified children is not counted.

SNAP

All income, except a prorated portion, is counted for a person disqualified for one of the following reasons:

- The applicant failed to provide or apply for a Social Security number.
- The applicant is an ineligible alien (including an alien awaiting sponsor information or proof of sponsor information).
- The applicant is waiting for verification of a questionable claim of U.S. citizenship.
- An able-bodied adult without dependents (ABAWD) has received the maximum months of benefits without meeting the SNAP ABAWD work requirement.

All income, unless otherwise exempt, is counted for a member disqualified for:

- intentional program violation;
- Employment and Training (E&T) noncompliance;
- felony drug convictions; or
- being a fugitive.

Disqualified people are considered household members although they are not allowed to participate.

Medical Programs

Calculate the MAGI household income for each individual applying for Medical Programs using the steps explained in A-1341, Income Limits and Eligibility Tests, Medical Programs.

A-1362.1 TANF – Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits

Revision 15-4; Effective October 1, 2015

TANF

For EDGs with a legal parent who is disqualified for one of the reasons above and who has income, advisors should follow the budgeting process below to determine the amount of the legal parent's income to count against the needs of the remaining certified group before applying the two needs tests.

1. Determine the legal parent's countable monthly gross earned income.
2. Subtract the standard $120 work-related expense deduction from earned income.
3. Add the disqualified parent's unearned income to the net earned amount and subtract the following three amounts:
    - The monthly amount the parent actually pays to a person living outside the home whom the parent can claim as a tax dependent or is legally obligated to support.
    - The monthly amount of alimony and child support payments the parent actually makes to persons outside the home.
    - The budgetary needs amount for the parent and other noncertified members in the home whom the parent can claim as tax dependents or is legally obligated to support (including SSI recipients). Use the needs figure applicable to the number of noncertified members (including the parent with income). **Note:** See A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, to determine:
        - whether to use the needs allowance of an adult or a child, or
        - the needs amount for more than two adults.

      Exception: Do not include the needs of a dependent who is disqualified for a reason other than citizenship.
4. Count the remaining income against the needs of the certified group.

Note: If a noncertified stepparent with income also lives in the home, complete the steps in A-1366.2, Stepparent Budgeting Procedures, before completing this process.

A-1362.2 TANF - Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence,

Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction

Revision 15-4; Effective October 1, 2015

TANF

The same budgeting procedures used for a certified household member are used for TANF, except the needs of the disqualified member are not included.

Exception: If the household member is not a required member of the certified group, the non-required member's needs are removed. Additionally, the non-required member's income and resources do not count against the remaining members of the certified group.

If the member has expenses for which income must be diverted, the policy in A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, should be followed.

A-1362.3 SNAP - Budgeting for Members Disqualified for Citizenship, SNAP ABAWD Work Requirement or Noncompliance with Social Security Number Requirements

Revision 20-3; Effective July 1, 2020

SNAP

All of the disqualified person's countable income should be totaled.

Notes:

- Income of an alien's sponsor is not applied to a sponsored alien who is disqualified.
- If a disqualified member receives TANF, the disqualified member's pro rata share of the TANF grant is counted, and each TANF recipient's portion of the grant is entered as TANF income.
- The disqualified person's countable income is divided by the number of household members, including the disqualified member. This determines the pro rata share of income.
- All pro rata shares of income are counted, except those of a disqualified member(s).

Earned Income Deduction — The EID is deducted from the part of the disqualified member's earned income that is counted in the household.

Standard Deduction — The appropriate standard deduction amount is applied only for eligible household members.

Dependent Care, Child Support Expense, Shelter Expense and Homeless Shelter Standard Deductions — These expenses billed to or paid by the disqualified member are divided equally among all SNAP household members, including the disqualified member. All pro rata shares are included in the household budget, except those of disqualified members. The allowable pro rata share is entered under an eligible SNAP household member.

Note: If only the disqualified member has income, the expenses must be considered to be paid by that member.

Utility or Telephone Deductions — The appropriate utility or telephone standard is allowed. Utility or telephone deductions are not prorated.

Medical Deduction — The actual medical expense or the standard medical deduction is prorated among all household members, and the pro rata share for a disqualified member's medical bills (including situations in which the disqualified member is billed for or pays the medical bills of a remaining eligible household member) is not allowed.

Note: If only the disqualified member has income, the expenses must be considered to be paid by that member.

Income Test and Household Size — The disqualified member is not included in determining the household income limits or the amount of the household's allotment.

Example of Procedures for Budgeting TANF Income of Households with Members Disqualified for Citizenship or Alien Status Who Are Eligible for TANF but Not SNAP

A household consists of a husband and wife and their four children. The husband and wife are lawful permanent residents, and their four children are U.S. citizens. The husband is unemployed, and the household receives a TANF-State Program grant of $294. Both the husband and wife are eligible for TANF but are disqualified aliens for SNAP.

For TANF and SNAP EDGs, TIERS will automatically prorate the TANF income for the SNAP budget, using the following formula.

Step	Action
1	Divide the TANF grant by the number of TANF-certified household members to arrive at the pro rata share for each member. $294 ÷ 6 = $49 (each member's pro rata share of the grant).
2	Multiply the pro rata shares of the grant by the number of TANF recipients who also are eligible for SNAP benefits. $49 x 4 = $196
3	Divide the disqualified person's pro rata share of the TANF benefits by the total number of SNAP household members, including the disqualified member(s). Count the pro rata share of TANF attributed to all eligible SNAP household members. $49 ÷ 6 = $8.17 x 4 = $32.68 (countable share of the husband's TANF) $49 ÷ 6 = $8.17 x 4 = $32.68 (countable share of the wife's TANF)
4	Determine the total countable TANF by adding the countable amounts from Steps 2 and 3. $196 (children's share) + $65.36 = $261.36.

A-1362.4 SNAP — Budgeting for Persons Disqualified for Intentional Program Violations, SNAP Employment Services Noncompliances, Felony Drug Convictions or Being a Fugitive

Revision 15-4; Effective October 1, 2015

SNAP

Income — All income of a disqualified member counts unless it is otherwise exempt.

Income Deductions — All income deductions and expenses of a disqualified member are allowed.

Standard Deduction — The disqualified member is not included in the household size when applying the standard deduction.

Shelter/Medical Deductions — Appropriate shelter and medical deductions are allowed even if the disqualified person is the only elderly person or person with disabilities in the household.

Although the household can receive uncapped shelter deductions, the household must still pass both the gross and net income tests if the disqualified person was the only elderly member or member with disabilities in the household.

Income Test and Household Size — The disqualified member is not included in determining the household income limits or the amount of the household's allotment.

A-1363 Diverting Income

Revision 22-1; Effective January 1, 2022

TANF

Divert income if a caretaker, second parent, minor parent or married minor has countable income and:

- pays alimony or child support to people outside the home;
- makes payments to people outside the home who the person can claim as tax dependents or has a legal obligation to support; or
- there are noncertified people living in the home who the person can claim as tax dependents or has a legal obligation to support, including SSI recipients and children receiving SSI Medicaid.

Also divert income if a noncertified stepparent lives in the home and:

- only the legal parent has income; or
- they both have income and the stepparent's income does not meet all of the stepparent's and the noncertified dependent's needs.

If both the stepparent and legal parent have income, follow the stepparent budgeting procedures before completing this process.

Line 1 – Payments to Dependents Outside Home — The actual amount of any payments made to people living outside the home who the parent or non-certified stepparent can claim as tax dependents or is legally obligated to support.

Line 2 – Alimony and Child Support Payments — The actual amount of alimony or child support payments the parent or noncertified stepparent makes to people outside the home.

Line 3 – 100 Percent Needs Amount — The budgetary (100 percent) needs figure for all noncertified members in the home who the legal parent or noncertified stepparent can claim as tax dependents or is legally obligated to support including SSI recipients. Exclude the needs of a parent or dependent who is disqualified for a reason other than citizenship, or immigration status, state time limits or the unmarried minor parent domicile requirement. Use the single parent caretaker needs figure if there is a noncertified stepparent in the home, or a second legal parent in the home who receives SSI or is disqualified for citizenship or immigration status, state time limits or noncompliance with the unmarried minor parent domicile requirement. Follow policy for diversions, alimony and payments to dependents outside the home to determine:

- whether to use the needs allowance of an adult or a child; or
- the needs amount for more than two adults.

Line 4 – Maximum Amount to Be Diverted — The total of lines 1, 2 and 3 except if following stepparent budgeting procedures. This is the **maximum** amount of diversions that can be deducted from the person's total income. The **actual** amount diverted in any needs test may be less, since the diverted amount cannot exceed the person's total income and be deducted from income of another household member unless they will be filing a joint income tax return, or they are married.
TIERS will complete this process based on the entries on the **Relationship** page.

Related Policy

Stepparent Budgeting Procedures, A-1366.2
Diversions, Alimony, and Payments to Dependents Outside the Home, A-1424

A-1364 Migrant Farm Workers in the Workstream

Revision 02-3; Effective April 1, 2002

SNAP

Migrant farm workers are people who have moved into a county looking for work cultivating crops, canning, or packing. The household must include at least one migrant farm worker to be classified as a migrant household.

A-1364.1 Guidelines for Determining Income of Migrant Workers

Revision 15-4; Effective October 1, 2015

All Programs

- Income should not be anticipated merely because there is work available in the area.
- Everyone in an area may not be employed, even if work is available.
- Future income counts only when the amount and month of receipt is known.
- The effect of future migrations must be considered since these migrations might interrupt the expected income.
- The grower, not the crew chief, is considered as the source of income.
- Travel advances and wage advances must be distinguished. If a travel advance is a reimbursement for travel expenses, the advance does not count as income. Wage advances for travel expenses count as income if the migrant worker has a written contract from the prospective employer that states the travel advance is a wage advance that will be deducted from wages earned later.
- The income of a student under age 18 must be separated from the rest of the migrant household's income. If the student's earnings or amount of work performed cannot be distinguished from that of other household members, the total income is divided equally among the working members, and the child's share is excluded.

A-1365 Unmarried Minor Parent Income

Revision 15-4; Effective October 1, 2015

TANF

The following steps should be followed when determining eligibility for households with an unmarried minor parent.

Note: Minor parent budgeting procedures are not used when determining eligibility for married minor parents.

Determine which of the following situations describes the household:

1.

Situation	Household Composition
A	minor parent minor parent's child deprived due to absence

Situation	Household Composition
	minor parent's legal parent(s) minor parent's minor siblings
B	minor parent minor parent's child deprived due to absence minor parent's legal parent and stepparent minor parent's minor siblings
C	minor parent minor parent's child deprived due to absence minor parent's legal parent and stepparent minor parent's minor siblings minor parent's legal parent's and stepparent's mutual child
D	minor parent legal parent of minor parent's child (not married to minor parent) minor parent's mutual child minor parent's legal parent(s) minor parent 's minor siblings
E	minor parent legal parent of minor parent's child (not married to minor parent) minor parent's mutual child minor parent's child deprived due to absence minor parent's legal parent(s) minor parent's minor siblings

2.

If the household situation is described in situation …	and the legal parent's choice to apply for TANF is …	include in the certified group …	using these budgeting procedures …
A minor parent minor parent's child deprived due to absence minor parent's legal parent(s) minor parent's minor siblings	yes,	all household members. Include the minor parent's child if the caretaker or payee requests that the child be certified. Treat the minor parent as a child.	count income according to TANF guidelines for exempt and countable income. If the household is ineligible, process the minor parent's application using "A" "no" if the minor parent wants to apply.
-	no,	the minor parent and minor parent's child deprived due to absence.	apply the legal parent's income using stepparent budgeting procedures (divert for the legal parent's and siblings' needs). Treat the minor parent's income according to adult caretaker policies.
B minor parent minor parent's child deprived due to absence minor parent's legal parent and stepparent minor parent's minor siblings	yes,	all members except the stepparent. Also include the stepparent if the legal parent is incapacitated (A-221, Who Is Included, No. 7). Include the minor parent's child if the caretaker or payee requests that the child be certified. Treat the minor parent as a child.	apply the stepparent's income if the stepparent is not included in the EDG. Follow the budgeting procedures in A-1366, Stepparent EDGs. If the household is ineligible, process the minor parent's application using "B" "no" if the minor parent wants to apply.
-	no,	the minor parent and minor parent's child deprived due to	apply the minor parent's legal parent's income using stepparent budgeting procedures (divert for

If the household situation is described in situation …	and the legal parent's choice to apply for TANF is …	include in the certified group …	using these budgeting procedures …
		absence.	the needs of the legal parent, stepparent, and siblings). Do not count the stepparent's income. Treat the minor parent's income according to adult caretaker policies.
C minor parent minor parent's child deprived due to absence minor parent's legal parent and stepparent minor parent's minor siblings minor parent's legal parent's and stepparent's mutual child	yes,	all household members. Include the minor parent's child if the caretaker or payee requests that the child be certified. Treat the minor parent as a child.	count income according to TANF or TANF-State Program guidelines for exempt and countable income. If the household is ineligible, process the minor parent's application using "C" "no" if the minor parent wants to apply.
-	no,	the minor parent and minor parent's child deprived due to absence.	follow the budgeting procedures in "B" "no" (also divert for the legal parent's and stepparent's mutual child).
D minor parent legal parent of minor parent's child (not married to minor parent) minor parent's mutual child minor parent's legal parent(s) minor parent's minor siblings	yes,	all household members except the other parent of the minor parent's mutual child. Include the minor parent's child if the caretaker or payee requests that the child be certified. Treat the minor parent as a child.	apply the income of the minor parent's child's noncertified other parent using stepparent budgeting procedures (divert for the needs of the other parent; also, divert for the other parent's mutual child's needs if the child is not included in the grant). If the household is ineligible, process the minor parent's application using "D" "no" if the minor parent wants to apply.
-	no,	the minor parent, minor parent's mutual child, and the other parent of the minor parent's mutual child.	apply the minor parent's legal parent' s income using stepparent budgeting procedures (divert for the legal parent's and the siblings' needs). Treat the minor parent's and second parent's income according to adult caretaker policies.
E minor parent legal parent of minor parent's child (not married to minor parent)	yes,	the same household composition policies as "D" "yes."	follow the budgeting procedures in "D" "yes." If the household is ineligible, process the minor parent's application using "E" "no" if the minor parent wants to apply.

If the household situation is described in situation …	and the legal parent's choice to apply for TANF is …	include in the certified group …	using these budgeting procedures …
minor parent's mutual child minor parent's child deprived due to absence minor parent's legal parent(s) minor parent's minor siblings	-	no,	the minor parent, minor parent's mutual child, and the other parent of the minor parent's mutual child. Also, include the minor parent's child deprived due to absence.	follow the budgeting procedures in "D" "No."

Notes:

- If the minor parent lives with both parents, allow the caretaker EDG with second parent needs figure when diverting their income.
- If the income of the minor parent's parent is diverted, do not count their resources. Refer to A-1247, Resources of Stepparents, for stepparents.
- When the parents of the minor parent apply for TANF and the diverted amount from the minor parent's stepparent is a negative number, divert the remaining amount from the minor parent's legal parent's income.
- Do **not** carry over any remaining diversion amount to other household members' income.

A-1366 Stepparent EDGs

Revision 15-4; Effective October 1, 2015

TANF

A stepparent's income is always considered when determining financial eligibility for the certified group.

Stepparent budgeting procedures are used when a minor parent and the minor parent's children living with the minor parent's parent are applying for TANF and they meet the criteria in A-221, Who Is Included, No. 6.

If the legal parent and stepparent live in the home and have mutual children, the household members cannot be separated. Both parents' income is budgeted using legal parent budgeting procedures.

Related Policy

New TANF Spouse's Earnings, A-1368

A-1366.1 How to Determine Budgeting Procedures in Stepparent EDGs

Revision 15-4; Effective October 1, 2015

TANF

The stepparent is included in the grant only if the stepparent wants to be included and:

- the stepparent is the only parent in the home, or
- both the legal parent and stepparent are in the home and the legal parent has a disability (according to procedures in A-1050, Deprivation Based on Incapacity).

If the stepparent is **included** in the grant, the stepparent's income and resources count as a legal parent's would be counted. The usual earned income deductions are allowed.

If the stepparent is **not included** in the grant, the stepparent's income is budgeted using the stepparent budgeting procedures in A-1366.2, Stepparent Budgeting Procedures, to determine the amount of monthly income to be applied to the certified group. These budgeting procedures should be followed even if the stepparent does not meet TANF citizenship requirements.

A-1366.2 Stepparent Budgeting Procedures

Revision 15-4; Effective October 1, 2015

TANF

The amount of the stepparent's income that is counted to meet the certified group's needs must be determined before applying either needs test, using the following process:

1. Total the stepparent's countable gross earned income.
2. Deduct the stepparent's work-related expenses ($120).
3. Add the stepparent's unearned income to the net earned amount.
4. Deduct the stepparent's actual support payments for tax dependents outside the home and monthly expenses for alimony or child support. Deduct an amount equal to the budgetary needs (100 percent) of a single parent caretaker EDG for the stepparent and the stepparent's noncertified tax dependents living in the home (do not include the needs of a dependent that is disqualified for a reason other than citizenship).

   Note: See A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, to determine:
   - whether to use the needs allowance of an adult or a child, or
   - the needs amount for more than two adults.
5. Apply the stepparent's remaining income to the certified group as unearned income.

Notes:

- Count the stepparent's applied income only from the date of marriage.
- Use stepparent budgeting procedures when a minor parent and the minor parent's children living with the minor parent's parent are applying for TANF and they meet the criteria in A-221, Who Is Included, No. 6.

See A-1363, Diverting Income, for the budgeting process when only the legal parent has income or the legal parent and stepparent have income.

A-1366.3 Budgeting Procedures in Stepparent EDGs When Both Parents Have Eligible Children for Whom They Want to Apply

Revision 15-4; Effective October 1, 2015

TANF

The following steps are used to determine eligibility and benefits for TANF:

1. Test eligibility for each parent's EDG individually as separate cases. Consider only the income and circumstances of the caretaker and children for whom the caretaker is applying. Do not apply the stepparent's income in this initial step.
2. If both applicants are eligible, work the TANF as separate cases for each EDG group. Do not divert or apply income from either parent.
3. If both EDGs are ineligible, deny them both.
4. If one EDG is ineligible and the other eligible, deny the ineligible EDG and rebudget the eligible EDG. Consider the ineligible parent a stepparent and apply the ineligible parent's income using stepparent budgeting procedures.

Notes:

- Divert income for an ineligible child from only one parent when budgeting for step 1 and step 3. Divert income from both parents for the same child only when they will be filing a joint tax return or they are married.
- If the household includes eligible mutual children, the household members cannot be separated. Budget both parents' income using legal parent budgeting procedures.

A-1367 Strikers

Revision 24-4; Effective Oct. 1, 2024

All Programs

A striker is anyone who participates with one or more other employees in a work slow-down or stoppage. This includes a stoppage resulting from the expiration of a collective bargaining agreement.

A striker's status ends only when the striker returns to the job, retires, quits, is locked out, or is fired, regardless of the length of the strike.

Do not use the services of people or organizations helping strikers to interview applicants participating in the strike or lock-out. HHSC does not give these third-party representatives or organizations access to Lone Star Cards or other documents and does not use the facilities of these third-party representatives or organizations in certifying strikers.

A person is not a striker if the person is:

- exempt from work registration on the day before the strike for any reason other than employment;
- not participating in the strike, but cannot work because of the strike;
- afraid to cross the picket line because of threatened harm; or
- locked out of the job by an employer, including a person who was on strike before the lock-out.

A-1367.1 Eligibility of Strikers

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

A family is not eligible for TANF, TP 08 and TA 31 for any month in which the caretaker or second parent is participating in a strike.

SNAP

A household with a striker is ineligible for SNAP unless the household:

- was eligible immediately before the strike; and
- is still eligible.

Pre-Strike Eligibility

The income of all household members (including the striker) is used as of the day before the strike. If the household is ineligible, the household is denied.

If the household was eligible before the strike, current eligibility should be computed.

Current Eligibility

1. The striker's income on the day before the strike should be compared with the striker's current income (including union benefits and part-time jobs). The higher of the two incomes counts.
2. The striker's income is added to the current income of other household members.

   If the household is not currently eligible, the household is denied.

   If the household is eligible based on both current and pre-strike income, the household is eligible if it meets all other eligibility criteria. Other eligibility criteria are considered the same as income. The household must be eligible currently and before the strike.

TP 40, TP 43, TP 44, TP 48, TP 33, TP 34, TP 35 and TP 36

This policy is not applicable to these programs.

A-1368 New TANF Spouse's Earnings

Revision 15-4; Effective October 1, 2015

TANF

The earnings of a TANF recipient's new spouse are excluded for six months, beginning the month after the date of the marriage if the total gross income of the budget group does not exceed 200 percent FPIL for the family size. This applies to both ceremonial and common law marriages.

The following individuals are included in the budget group:

- the caretaker or payee of the TANF-certified group;
- the new spouse of the TANF caretaker or payee;
- each dependent of the TANF caretaker or payee and the new spouse who meets the TANF age and relationship requirements and lives in the household; and
- anyone who would be a required member if not disqualified or ineligible such as an SSI recipient or ineligible alien.

If the household fails to provide verification of the marriage, the income exclusion is not allowed. The amounts previously excluded count after six months.

A-1370, Verification Requirements

Body

Revision 24-4; Effective Oct. 1, 2024

All Programs

Verification used for SNAP or TANF is acceptable for:

- the other program unless it is inconsistent with other information or is questionable; and
- medical programs unless policy for a specific type of verification specifically says otherwise.

Verification used for medical programs is acceptable for SNAP or TANF unless policy for a specific type of verification says otherwise.

Verification of earned and unearned income is not required for any pay amount older than 60 days before the interview date.

Verify:

- if a child meets the earned income exemption criteria;
- tip income, if not included on a person’s wage statement;
- any breaks in pay periods;
- all loans or contributions, including cash or vendor payments;
- vacation pay before or after a job ended;
- if paid vacation after the job ended, verify if the person got a lump sum or multiple checks;
- the death of an alien's sponsor;
- for people who are striking:
  - the probable length of the strike;
  - the striker’s wages from that company; and
  - the striker's benefits or any help the striker is getting from the union.

At redetermination, verify interest income by:

- using the household’s statement if the amount has not changed by more than $50 and the income source has not changed; or
- requesting additional verification if the amount changed by more than $50 or there is new or different source of interest income.

If all attempts to verify income are unsuccessful because the payer fails or refuses to give information and no other proof can be found, use the best available information to determine the budget amount.

Related Policy

Prudent Person Principle, A-137
Children's Earned Income, A-1323.1
Strikers, A-1367
Verification Sources, A-1641
Verification and Documentation, C-900

TANF and SNAP

Verify all countable income at initial application, redetermination and when a household reports a change, **even if** the amount reported makes the household ineligible.

Use earned income and employment information from third-party income databases such as The Work Number (TWN) when the information is reasonably consistent. Information from a third-party income database is considered reasonably consistent if the income difference is equal to or less than $125 of the monthly pay amount reported by the household. Request additional verification when the third-party income database information is not reasonably consistent with monthly pay amount reported by the household.

Use the following steps to get income information when adding a new member, for employable household members who have no prior certification history or who have had a month or more break in certification.

Step	If yes,	If no,
1. For the month of application or two months before, did any household member have any earned or unearned income that ended?	Verify and document the: • source; • final gross amount and date received; • reason the income ended; and • end date. **Go to Step 2.**	**Go to Step 2.**
2. Is the household claiming no income?	If the claim is questionable: • follow policy in A-1700, Management; or • verify per C-920, Questionable Information.	**STOP.**

Related Policy

Management, A-1700
Questionable Information, C-920

TANF

Verify the date of marriage between a TANF recipient and the new spouse to determine the six-month period that the new spouse's earnings can be excluded as income.

TP 08

Verify the following to establish eligibility for TP 07:

- increase in gross earnings; and
- date the earnings or hours increased.

If verification is not available, use the person's statement, unless questionable.

If the household gives earnings information sufficient to determine ineligibility for TP 08, but does not give proof of the earnings, the household members should be transferred to TP 07 if they meet the eligibility requirements.

Related Policy

TP 07 Transitional Medical Programs, A-842

TANF and Medical Programs

If at application a person claims to have a disability or is caring for a child with disabilities, verify at the first redetermination that the person has applied with the Social Security Administration (SSA) for RSDI or SSI.

SNAP

Verify:

- A change based on best available information if:
  - an increase in earnings results in a decrease in benefits;
  - the person fails to give information; and
  - staff can compute benefits based on the information provided.
- the alien sponsor's status. If questionable, the household must:
  - contact U.S. Citizenship and Immigration Services (USCIS) for verification of sponsor status; or

    - participate without the alien member.
- a disqualified person's income the same as any other member.
- combat pay included in any income made available to the household by an absent military person, including the combat zone where the person is deployed.
- migrant income. If the household states the migrant workers work for various growers or crew chiefs, the household should be given a calendar form with space to record each day's income and hours worked. The household should get the grower or crew chief's signature for validation and present the form at the next interview.
- earned income and employment information using TWN data provided through the Federal Data Services Hub (FDSH).
- Note: no additional verification of income is required when reactivating a SNAP EDG at redetermination that was denied for failure to provide information. Use the income verification the household provided at the interview date, unless the household reported a change in income after the interview date.

Related Policy

How to File an Overpayment Referral, B-730
Required Verification for SNAP, C-912

Medical Programs

Verify all countable income at initial application, redetermination and when a household reports a change, **unless** the amount reported makes the household ineligible.

Request additional verification only if:

- acceptable verification is not available through electronic data sources; or
- information obtained electronically is not reasonably compatible with the person’s statement of income provided on the application or at redetermination.

Income from electronic data sources is considered reasonably compatible with income reported by a person when both the income reported by the person and electronic data are at or below the applicable income limit.

The system determines if a person's income is reasonably compatible with available electronic data sources. If the person's statement of income is not determined to be reasonably compatible with electronic data, verify income using other acceptable verification sources.

A person’s statement of income is not reasonably compatible with electronic data if:

- their statement of income is above the applicable FPL;
- their statement of income is below the applicable FPL, but electronic data indicate that income may be above the applicable FPL;
- the person has unverified countable expenses that need to be verified for the person to be determined income-eligible;
- sufficient information such as income type, income frequency, and income amount is not provided by the person to calculate a monthly income;
- income sources are provided that are not available from electronic data;
- the person has unverified countable income other than earned income, RSDI or unemployment; or
- TIERS is unable to access a third-party system to get electronic data, or electronic data was insufficient to complete reasonable compatibility.

When determining ongoing eligibility, the person is not required to provide verification of earned or unearned income of any pay amount older than 60 days before the interview date or the date the action is initiated when an interview is not required.

Do not request additional verification if:

- verification is available through TWC inquiry or other automated systems considered acceptable verification sources and accessible to staff; or
- the person confirms the information obtained through data sources is accurate and representative; and
- the information is sufficient to establish current eligibility.

Note: A Data Broker Combined Report cannot be requested for children under 16. Request additional verification if earned income is reported for a child under 16 who does not meet an exception explained in A-1341, Income Limits and Eligibility Tests, for Medical Programs, Step 3, and other electronic data sources are unavailable.

If the person reports that someone living at that physical address receives American Indian/Alaska Natives (AI/AN) income and includes an amount but does not provide the name of the person receiving the AI/AN income, pend for missing information. If the person:

- Fails to provide the missing information by the final due date, then the EDG will be denied for failure to provide information.
- Provides the name of the person receiving the AI/AN income but does not provide verification for the income type, then the income will be counted instead of being exempt. However, the EDG will not be denied for failure to provide information. The person will still be eligible for exemptions from cost-sharing if they are eligible for CHIP.

If the person indicates someone is eligible to receive services from Tribal or Indian Health Services, but they did not include the name of the person receiving services, then pend for the name. If the name is not provided by the final due date, then the EDG will not be denied, but the exemption will not be allowed for cost-sharing if the applicant is eligible for CHIP.

TP 40

After certification, a TP 40 EDG must not be denied for failure to provide proof of income unless income verification was postponed at certification.

A-1371 Verification Sources

Revision 24-4; Effective Oct. 1, 2024

All Programs

Verify the income budgeting requirements using the following verification sources.

Alien Sponsor's Death

The Texas Bureau of Vital Statistics (BVS) is the primary verification source for death. If BVS is available, but the date of death (DOD) does not match reported information, accept BVS as verification. No additional verification is required.

If BVS verification is not available, verify the DOD using two of the following sources:

- Social Security Administration (SSA);
- statement from guardian or authorized representative;
- copy of death certificate;
- statement from a doctor;
- newspaper death notice (obituary);
- statement from a relative or household member;
- statement from funeral director; or
- records from the hospital or other institution where the person died.

Alien Sponsor's Status

Written or verbal statement from the household, unless questionable.

Application for SSI or RSDI

- WTPY/SOLQ; or
- receipt from the SSA.

Contributions

- written statement from the person or agency giving the money to or making the payment for the household member;
- copy of the contribution check;
- copy of the canceled check from the person making the contribution; or
- proof of payment records for MyGoals cash payments.

Earned Income

- Form H1028, Employment Verification (PDF). Make sure the employer completed all items, and the information is consistent with reported information. If information is not consistent, resolve any discrepancies.
- Written letter from the employer that provides current income and frequency of payment(s).
- Signed and dated statement from client for tip income not included on the wage statement.
- Two pay amounts from the period starting 45 days before the file date through the interview date or the date the EDG is being processed if an interview is not required. Consider any information the person reports between the application file date and the decision date when determining eligibility.
- Do not use pay stubs as the only source of verification if the person:
  - began employment in the application or interview month;
  - reported new employment after certification;
  - ended employment in the application month; or
  - ended employment in the two months before application (TANF and SNAP only).
- written or verbal statement from the employer, union or company officials by mail, fax or phone.
- TWC wage records.

- Form H2583, Choices Information Transmittal, if the form is complete and shows the employer verified the information.

Related Policy

Information Reported During Application Processing, B-116
How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income, A-1355.2

Migrant Farm Income

- Employment Services;
- Farm Labor bureaus;
- Rural Manpower Development;
- Farmer's Cooperative Service;
- growers' associations;
- migrants' service organizations;
- county agents; or
- individual growers and crew chiefs.

Military Deployment and Combat Pay

- the military person's leave and earning statement (LES);
- the military person's issued orders; or
- contact the financial office at the local base.

Note: The military person's leave and earning statement (LES) is often sent directly to the family, or the deployed military person can mail it to the family back home. The military person's LES is acceptable verification of any combat pay being received and of deployment to a designated combat zone.

Other Income

- check or copy of check;
- statement from the bank paying dividends and interest and accept the person's statement on periodic reviews and timely recertifications;
- statement from the company or union providing pensions or union benefits; or
- Form H1050, Check Verification (PDF).

Other Government Benefits

- current award notice, letter or official statement;
- check or copy of check;
- agency contract or record; or
- statement from a Texas Department of Family and Protective Services advisor or representative.

RSDI

- WTPY/SOLQ;
- State Data Exchange (SDX) file, a source that also provides sufficient proof of SSI income available for an RSDI recipient;
- current award notice, check, letter or statement from the SSA;
- direct deposit slip from a financial institution; or
- Form H1050.

Railroad Retirement Benefits

- Form H1026, Verification of Railroad Retirement Benefits (PDF);
- current award notice, letter or statement from the Railroad Retirement Board;
- check or copy of check;
- direct deposit slip from a financial institution; or
- phone contact with a Railroad Retirement Board representative.

Self-employment

- IRS Schedule C, Form 1040 – Profit or Loss from Business;
- previous year's IRS tax return or business records for self-employment income received less often than monthly;
- most recent business records and receipts;
- Form H1049, Client's Statement of Self-Employment Income (PDF); or
- written client statement of estimated earnings or receipts for goods and services provided.

Note: If collateral contacts or documented information does not verify the income and expenses, use Form H1049.

Strikers

Union and company officials

Texas Lottery Commission

Data Broker System

Unemployment Compensation

- check or copy of check;
- current award notice, letter or statement from TWC;
- former employer;
- TWC inquiry; or
- statement from TWC verifying the primary wage earner's application for unemployment insurance benefits.

TANF and SNAP

In addition to the verification sources listed for All Programs, verify income using the following verification sources.

Child Support

- Texas Child Support Enforcement System (TXCSES) inquiry;
- Office of the Attorney General (OAG) child support data;
- check or copy of check;
- county clerk records;
- canceled checks with three months if possible;
- wage withholding statements;
- withholding statements from unemployment compensation;
- written statement from the parent providing support; or
- current court records such as court order, court support agreement, or divorce or separation papers.

Related Policy

Data Broker, C-820
OAG Child Support Data, C-825.14.1
Office of the Attorney General (OAG) Inquiry, C-832
TXCSES Web Child Support Portal Inquiry, C-833

Earned Income

Third-party income databases such as The Work Number (TWN) when the information is reasonably consistent.

Educational Grants, Scholarships or Loans

- Statement, letter, or records from:
  - schools;
  - organizations, clubs, or agencies providing benefits; or
  - Veteran’s Administration (VA) for veteran's educational benefits.

SSI

- WTPY/SOLQ;
- State Data Exchange (SDX) interface;
- check or copy of check;
- current award notice, letter, or written statement from the SSA; or
- direct deposit slip from a financial institution.

Veterans and Department of Defense (DoD) Benefits

- current award letter or notice;
- written letter or statement from VA or Defense Finance and Accounting Service (DFAS);
- contact with a VA representative at 800-827-1000;

- contact with a DFAS representative at 800-321-1080; or
- Form H1240, Request for Information from Bureau of Veterans Affairs and Client's Authorization (PDF).

Workers' Compensation

- current award notice, letter or statement from:
  - a claims adjuster;
  - an attorney; or
  - an insurance company; or
- check or copy of check.

TANF

Verify the marriage date to determine the income budgeting requirements for the new spouse using the following verification sources.

Ceremonial Marriage

- marriage license or certificate;
- church records;
- statement from clergy; or
- family Bible records.

Common Law Marriage

- Declaration of Informal Marriage filed with the county clerk;
- sworn statement signed by both spouses; or
- Form H1057, Declaration of Informal Marriage (PDF).

Medical Programs

Electronic data sources with reasonable compatibility are the preferred method of wage verification for Medical Programs. If unverifiable by ELDS, verify income and employment information using the following sources.

Earned Income

TWN.

Related Policy

Verification Requirements, Medical Programs, A-1370

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

In addition to the verification sources listed for All Programs, verify income using the following verification sources.

Earned and Unearned Income

- pay stub issued in the last 60 days; or
- most recent tax return.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A-1380, Documentation Requirements

Body

Revision 25-4; Effective Oct. 1, 2025

All Programs

Exempt Income — Document the:

- reason the income is exempt; and
- name and address or phone number of the income source.

Terminated Income — Document any:

- income that terminated in the application month; and
- vacation pay received before or after termination, including the dates received.

Income — Document the:

- date of each income statement or pay stub used;
- date income was received;
- date income is expected using factors such as mail time, direct deposit or electronic transfers, weekends and holidays;
- name and address or phone number of the income source;
- gross amount of income;
- frequency of receipt, such as weekly, every two weeks, semi-monthly or monthly;
- breaks in pay periods; and
- calculations used.

Notes:

- If other means are used to verify earned income, include in the documentation information comparable to that listed above. Document the payback amount and gross amount used in the budget for advances per policy.
- Complete the appropriate screens in TIERS if using Texas Workforce Commission (TWC) quarterly wage records.

Fluctuating Income — Document:

- the reason for income fluctuations; and
- why a pay period was included or excluded in the projection. If a pay period is not representative of future earnings, document the reason it is not representative.

Income Computations — Document verification and computation of household income:

- at the initial application;
- when a change is reported; and
- at each subsequent application or redetermination.

Note: All sources, amounts, dates and computations must be recorded.

Other Income — Document the method used to verify income other than earned and TANF income, including the:

- type of income;
- check or another document viewed;
- date on the check or other document;
- amount recorded on the check or other document;
- date the income was verified; and
- computation performed to determine the total income.

Self-Employment — Document:

- the method for averaging income;
- deductions for the costs of doing business;
- the number of hours engaged in the enterprise; and
- other factors used to determine the amount of income.

Notes:

- Document the reason if Form H1049, Client's Statement of Self-Employment Income, is the only source of verification.
- When self-employment income is added to the case record, a statement is included on Form TF0001, Notice of Case Action, to remind the self-employed person to keep records and receipts for future verification.

Alien Sponsor's Income — Document that an indigent alien exempt from deeming requirements, was informed that the state office is required to report the indigent alien's sponsor to the United States Citizenship and Immigration Services (USCIS). If the alien does not want the report sent to the USCIS, document that the alien chose to have the sponsor's income deemed.

TANF and SNAP

Terminated Income — Document any income that terminated in the two months before the application month, including:

- source of income;

- gross amount of final check and date received;
- reason for termination; and
- date of termination.

TANF

Document the household's plan to pursue legally entitled income and the time allowed to pursue the income.

Document when a person no longer claims to have a disability or to be caring for a child with a disability when they reapply after a denial for failure to follow the agreed plan to apply for SSI or RSDI.

Document the six-month period to exclude the earnings of a new spouse of a TANF recipient.

Document the person's decision not to apply for SSI, when they are not required to pursue SSI because:

- they are physically or mentally unable to complete the application process; and
- SSA fails or is unable to give needed assistance to complete the SSI application process.

Document a person's decision to stop claiming a Choices exemption for disability or caring for a child with a disability when the person failed to apply for SSI or RSDI without good cause.

Related Policy

Requirement to Pursue Income, A-1311
SSI/RSDI Application Assistance, A-1311.1.1
Wages, Salaries, Commissions, and Tips, A-1323.5
Documentation, C-940
The Texas Works Documentation Guide

A-1400, Deductions

A-1410, General Policy

Body

Revision 21-2; Effective April 1, 2021

All Programs except TP 45

Certain deductions may be allowed when determining countable income.

TANF

Households may be allowed the following deductions:

- work-related expense deduction (up to $120);
- 90 percent earned income deduction;
- dependent care;
- diversions; and
- $75 disregard.

SNAP

Households may be allowed the following deductions:

- 20 percent earned income deduction for households with earnings;
- standard deduction;
- medical costs for household members who are elderly or have a disability;
- dependent care;
- child support paid to or for non-household members;
- homeless shelter standard;
- excess shelter costs; and
- Plan for Achieving Self-Sufficiency (PASS).

Medical Programs except TP 45

Households may be allowed the following Modified Adjusted Gross Income (MAGI) deductions:

- standard MAGI income disregard;
- alimony paid*;
- educational expenses or student loan interest;
- moving expenses (allowed only for active duty members of the military who are moving duty stations);
- tuition or GI Bill deduction;
- educator expenses;
- expenses of fee-basis government officials, expenses of performing artists, and expenses of reservists;
- health savings account;
- deductible part of self-employment tax;
- self-employed individual retirement account (IRA), simple IRA, and qualified plan deductions;
- self-employed health insurance;
- penalty on early withdrawal;
- IRA deduction; and
- domestic production activities deduction.

***Note**: Alimony paid cannot be claimed as a MAGI deduction for divorce or separation agreements that are executed or modified after Dec. 31, 2018.

Persons with divorce or separation agreements effective on or before Dec. 31, 2018, can continue to claim alimony paid as a MAGI deduction until the agreement is modified. Follow verification and documentation policy when verifying the date of the divorce or separation agreement and the amount paid in alimony to allow the deduction.

TP 45

Because there is no income test, deductions are not considered as a factor in determining eligibility for TP 45.

Related Policy

Verification Sources, A-1441
Documentation Requirements, A-1450

A—1411 Rules That Apply to Deductions

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Actual amounts (amounts that have already been billed) are used for the interview month, and amounts that have not been billed may be projected.

- The following expenses are not deducted:
  - expenses paid to another member of the same Eligibility Determination Group (EDG);
  - expenses paid by a reimbursement, an exempt vendor payment or in-kind benefit (**Exception:** For the Supplemental Nutrition Assistance Program [SNAP], see A-1428.1, Allowable Medical Expenses, and A-1429.3, Utility Allowances); or
  - past-due balances, late charges or finance charges. **Exception:** For SNAP, expenses such as property tax that are averaged over the period between scheduled billings or over the period the expense is intended to cover are allowable even if the expense is paid or past due when reported.
- The most recent month's bills are used to project expenses, and unexpected changes should be considered during the certification period.
- Only household expenses expected during the certification period should be considered.
- The income conversion factors are used to determine monthly expenses if expenses are billed weekly, biweekly or semi-monthly.

Deductions must not be allowed if:

- verification of the expense is required;
- the household fails to provide required verification; and
- the advisor is not able to verify the expense directly using other automated systems that are acceptable verification sources and accessible to the advisor or through another method.

Note: The EDG must not be denied for failure to provide the verification.

SNAP

- An expense is allowed, regardless of when or if the household intends to pay it.
- If expenses are not averaged, the expenses should be deducted in the month the expense is billed (or the month it becomes due if no bill is sent). **Exception:** See A-1428.4, Change in Medical Expenses During Certification.
- A deduction for expenses that are legally due monthly is allowed even when the household pays them in advance.
- Households may choose to average expenses that fluctuate or occur less often than monthly. These expenses are averaged over the:
  - interval between scheduled billings, or
  - period the expense is intended to cover if there is no scheduled billing.

    Note: If the individual reports a change, the average is recalculated.
- If the individual agrees with the provider to make installment payments for an allowable one-time expense, the individual can choose to have the agreed upon payments budgeted as the amount due in a given month.

Medical Programs except TP 45

MAGI rules allow certain expenses to be deducted from the individual's income in order to determine the MAGI individual income.

- For all MAGI expenses that have been verified using last year's federal income tax return, take the expense amount from the federal income tax return and divide that amount by 12 to determine the monthly expense amount for use for applicant or recipient.
- For the alimony paid expenses verified using other acceptable verification sources, use the actual amount verified for the MAGI alimony paid expense.

A-1420, Types of Deductions

Body

Revision 12-3; Effective July 1, 2012

A-1421 Child Support Deductions

Revision 15-4; Effective October 1, 2015

TANF

Diversion policy in A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, applies.

SNAP

Advisors should deduct child support payments (current or arrears) that a household member is legally obligated to pay and that member or another household member:

- actually pays **to** an individual outside the SNAP household; or
- actually pays **for** an individual outside the SNAP household; or
- makes to a child support agency.

A-1421.1 Allowable Child Support Deductions

Revision 15-4; Effective October 1, 2015

SNAP

Allowable child support payments may be in the form of:

- cash support;
- medical support; or
- payments to third parties.

To be an allowable deduction, these payments must be ordered by a court or administrative authority and be equal to or less than the household's child support obligation.

Payments for alimony or spousal support are not deductible.

A-1421.2 Budgeting Child Support Deductions

Revision 24-2; Effective April 1, 2024

TANF and SNAP

Child support collected through a tax intercept is not an allowable child support deduction.

A child support payment may be owed by one household member but paid by another member. The child support expense for the household member paying the expense is allowed.

If the household member with the legal obligation or the household member paying the legal obligation leaves the home, the household's eligibility for the deduction must be redetermined.

SNAP

A child support deduction for households that pay legally obligated child support is allowed. For current support, a deduction up to and including the legally obligated amount is allowed. For arrears, only the amount a household member actually pays is allowed.

For households with new obligations, the anticipated amount is budgeted if the household member can reasonably explain the basis for future payment. For households with previous payments, the amount, not to exceed the legal obligation, is averaged and projected over the certification period. Consider any other anticipated changes that will affect the payment.

When child support is collected by an employer through wage garnishment or by the custodial parent through a private collection agency, the absent parent may be charged a processing fee. The processing fee is not an allowable expense. Only the legally obligated amount a household member pays is allowed as a deduction, even if a processing fee is added or subtracted from the gross amount of the child support.

If a household member pays child support in advance, the household is eligible for the child support deduction. The household is allowed the option of deducting the entire amount in the month paid or averaging the amount over the period it is intended to cover.

If legally obligated child support is paid by a household member who is disqualified due to	then
intentional program violation, employment sanction, felony drug convictions or being a fugitive,	deduct the entire amount of eligible child support paid.
alien status, citizenship, Social Security number or ABAWD work requirement,	prorate the amount of eligible child support paid by the disqualified member. Deduct all but the disqualified member's share.

The full child support expense is deducted when another household member pays the legally obligated child support on behalf of a disqualified member.

Related Policy

SNAP — Budgeting for Members Disqualified for Citizenship, SNAP ABAWD Work Requirement or Noncompliance with Social Security Number Requirements, A-1362.3
SNAP — Budgeting for Persons Disqualified for Intentional Program Violations, SNAP Employment Services Non compliances, Felony Drug Convictions or Being a Fugitive, A-1362.4

A-1422 $75 Disregard Deduction

Revision 15-4; Effective October 1, 2015

TANF

Up to $75 of child support received before the certification date may be deducted.

Related Policy

Child Support, A-1326.2

A-1423 Dependent Care Deduction

Revision 23-1; Effective Jan. 1, 2023

TANF

The maximum dependent care deduction is:

- $200 a month for each child under 2;
- $175 a month for each child 2 or older; and
- $175 a month for each adult with disabilities.

An earned income deduction is allowed for the actual cost of unreimbursed payments up to and including the maximum amount when the person incurs an expense for:

- the care of a child or adult with disabilities, even when the child or adult with disabilities is not included in the certified group;
- the transportation of a child or adult with disabilities to and from day care or school; or
- activity fees associated with a structured dependent care program.

Note: Activity fees do not have to be a required cost to participate in the program, but the fees must be an explicitly defined cost.

The dependent care expense must be necessary for employment and incurred by an employed person included in the Temporary Assistance for Needy Families (TANF) budget group or who would be included except the person is disqualified for one of the following reasons:

- non-compliance with Social Security Number (SSN);
- third party resource;
- failure to timely report a child's temporary absence;
- intentional program violation;
- being a fugitive; or
- having a felony drug conviction.

Allow the expense for household members who meet these requirements, even if there are other adults in the household who could care for the child or disabled adult. The person's expense may be considered necessary for employment, training, or school attendance if the child or adult with disabilities lives with the person at least one day a month.

The deduction in the budgetary and recognizable needs tests is allowed.

SNAP

A deduction is allowed for the actual cost of unreimbursed payments when the person incurs an expense for:

- the care of a child or adult with disabilities even when the child or adult with disabilities is not included in the certified group;
- the transportation of a child or adult with disabilities to and from day care or school; or
- activity fees associated with a structured dependent care program.

Note: Activity fees do not have to be a required cost to participate in the program, but the fees must be an explicitly defined cost.

The dependent care deduction is allowed if the expense is necessary for a household member to seek or continue employment, attend training or go to school.

Allow the expense for household members who meet one of the above conditions, even if there are other adults in the household who could care for the child or adult with disabilities. These expenses are deducted from earned or unearned income. The person's expense may be considered necessary for employment, training or school attendance if the child or adult with disabilities lives with the person at least one day a month.

Related Policy

Disqualified Members, A-1362

TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction, A-1362.2

A-1424 Diversions, Alimony, and Payments to Dependents Outside the Home

Revision 21-2; Effective April 1, 2021

TANF

The following deductions from the income of a caretaker, second parent, or minor parent are allowed before either of the two needs tests are applied (after earned income deductions in the budgetary and recognizable needs tests):

- Budgetary needs amount for a family size equal to the number of noncertified persons in the home whom the legal parent can claim as tax dependents or is legally obligated to support (including Supplemental Security Income [SSI] recipients). The needs figure applicable to the number of noncertified members is used.
    - An amount for the needs of a dependent who is disqualified for a reason other than citizenship, alien status, time limits, or unmarried minor parent domicile requirement is not diverted.

- Actual amount of child support and alimony a household member pays to persons outside the home.
- Actual amount of a household member's payments to persons outside the home whom a household member can claim as tax dependents or is legally obligated to support.

When two household members are married or filing a joint tax return, any portion of their joint diversion amount that exceeds one person's income can be deducted from the other person's income.

Step 3 on Form H1100, Addendum Income Worksheet, should be completed to allow this deduction.

Medical Programs

If the divorce or separation agreements that include alimony payments were executed or last modified:

- On or before Dec. 31, 2018, alimony paid by members of the MAGI household can be deducted.
- After Dec. 31, 2018, alimony paid cannot be claimed as a MAGI deduction.

A-1424.1 Determining the Needs Figure

Revision 15-4; Effective October 1, 2015

TANF

The following table may be used when diverting for the needs of noncertified tax dependents in the home.

If the tax dependent is a ...	then use the budgetary needs figure for ...
• parent, • spouse (including spouse of child), or • child age 19 or older,	an adult.*
child under age 19,	a child.

* If the number of persons whose needs are diverted includes more than two adults, use the chart figure for two adults and the number of children from the column labeled Caretaker EDGs With Second Parent. If there are a total of three adults, add an additional amount from the chart for the family size of one ($313); or if there are a total of four adults, add an additional amount from the chart for a family size of two ($498). Continue the pattern depending upon whether the number of additional adults is an odd number (5 = $498 + $313) or an even number (6 = $498 + $498).

When diverting for an 18-year-old child who turns age 19 during one of the budget months, the budgetary needs figure of an adult is used beginning with the month after the child turns age 19.

A-1425 Earned Income Deductions

Revision 15-4; Effective October 1, 2015

TANF

Earned income deductions are the:

- standard work-related expense (up to $120);
- 1/3 earned income disregard for applicants;
- 90 percent earned income deduction; and
- dependent care costs.

An applicant or recipient does not qualify for deductions if:

- income is gained from illegal activities, such as prostitution and selling illegal drugs.
- the individual did not notify the Texas Health and Human Services Commission (HHSC) timely about a new job or increased earnings without good cause. Allow the deduction for ongoing budgets, but do not allow it when determining an overpayment or supplemental budgets. Count the months it should have been budgeted as used months based on when the change would have been effective if the individual had reported it timely.

- individual voluntarily quits a job without good cause within the 60 days prior to the:
  - application file date, or after filing but before certification; or
  - household addition request date, or after the request but before being added. Deductions are not allowed until the next complete review.

    Deductions beginning with the Texas Integrated Eligibility Redesign System (TIERS) effective month are allowed when processing the next complete review.

SNAP

A 20 percent deduction of all gross earned income is allowed. See B-752, Determining Claim Amounts, for exceptions.

A-1425.1 Work-Related Expense ($120 and 20%)

Revision 15-4; Effective October 1, 2015

TANF

A work-related expense deduction of up to $120 a month (not to exceed the person's monthly earnings) is allowed from the earned income of each employed household member:

- whose needs are included in the budget or certified group; or
- who is a disqualified member.

In TANF, this deduction is allowed in the budgetary and recognizable needs test.

SNAP

Allow a 20 percent deduction of all gross earned income.

A-1425.2 1/3 Disregard for Applicants

Revision 15-4; Effective October 1, 2015

TANF

Applicant households that must pass the 100 percent budgetary needs test are also required to pass Part A of the 25 percent recognizable needs test. This Part A test allows the standard work-related deduction ($120) and a disregard of 1/3 of the remaining income. If the applicant fails this test, the household is ineligible for TANF.

Note: For this purpose, an applicant household is one that has not received TANF in any state in the four months before applying.

A-1425.3 90% Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

Applicant households that pass Part A of the recognizable needs test and all other households must pass Part B of the test (see A-1341, Income Limits and Eligibility Tests). After subtracting the standard work-related expense, 90 percent of the remaining earnings (up to a cap of $1,400) is subtracted. This deduction is allowed for each employed household member who is eligible for it. The individual can receive this deduction for four months in a 12-month period. The four months do not have to be consecutive. **Note:** A month in which a full-family sanction is imposed is not counted as one of the 90 percent earned income deduction (EID) months.

The 12-month period is a fixed period that begins with the first month the 90 percent deduction is used. The first month that counts as a used month is the first month the individual receives a cash benefit that includes the 90 percent deduction. This period is referred to as the 90 percent EID eligibility period.

If the individual has not used all four months of the deduction within the 90 percent EID eligibility period, a new fixed 12-month period and four new months of the 90 percent EID are allowed after the first 12-month period ends. The new 12-month period begins with the first month that the individual uses the 90 percent deduction again.

If the household member received the 90 percent deduction for four months in a 12-month period, the member may not receive it again until:

- TANF is denied and remains denied for one full benefit month; and

- 12 calendar months have passed since the denial. This 12-month period is known as the 90 percent EID ineligibility period and begins with the first full month of denial after the individual used the fourth month of the 90 percent deduction.

A-1425.3.1 Who Is Eligible for the 90% Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

A household member is eligible to receive the 90 percent EID if:

- the individual has not previously received the deduction for four months in the individual's 12-month period; and
- the individual's needs:
  - are included in the certified group; or
  - would be included except the individual is disqualified for noncompliance with child support, Social Security number (SSN), Choices, third-party resource (TPR) requirements, intentional program violation (IPV), or for reasons other than alien/citizenship status, TANF state time limit policies, and the TANF unmarried minor parent domicile requirement.

TIERS default settings automatically allow the 90 percent EID for eligible EDG members. The 90 percent EID page appears by choosing the screen from the left navigation bar. The effective begin and end dates are used to allow the deduction for specific months.

An individual may decline use of the deduction even if it results in EDG denial without its use. The individual may decline at any time, but the deduction may not be removed retroactively. Any removal from the budget will take effect according to timely change processing for future months.

If the client wishes to decline the deduction, the client answers "yes" to the questions, "Does individual decline the TANF 90 percent earned income deduction?" and "Does individual decline the FMA 90 percent earned income deduction?" on the 90 percent Earned Income Deduction – Details screen. TIERS requires answers for both questions.

A-1425.3.2 Who Is Not Eligible for the 90% Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

An individual is not allowed the deduction if any of the situations listed in A-1425, Earned Income Deductions, apply to the individual.

An individual is not allowed the deduction if the member's needs are not included in the EDG because the member is disqualified due to:

- alien/citizenship status;
- TANF state time limits policies; or
- TANF unmarried minor parent domicile requirement.

The deduction is not allowed if the individual has already received the 90 percent deduction for four months in a 12-month period. When the 90 percent ineligibility period ends, the deduction is not allowed again until the individual obtains new employment. The new employment must begin after the 90 percent ineligibility period ends.

A-1425.3.3 Removing the 90% Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

After the individual receives the 90 percent deduction for four months in a 12-month period, the deduction ends. TIERS automatically removes the deduction and rebudgets the EDG for the appropriate month based on advisor entries.

A-1426 Reserved for Future Use

Revision 20-2; Effective April 1, 2020

A-1427 Homeless Shelter Standard

Revision 15-4; Effective October 1, 2015

SNAP

The homeless shelter standard shown in C-121.1, Deduction Amounts, is budgeted for any month the household:

- meets the definition of a homeless household;
- has any amount of out-of-pocket shelter expenses; and
- chooses the standard.

Households that choose the homeless shelter standard are not entitled to any other shelter deductions or utility standards.

Note: Advisors must ensure that the household has out-of-pocket shelter expenses before allowing the deduction.

A-1428 Medical Deduction

Revision 15-4; Effective October 1, 2015

SNAP

A medical deduction is allowed for households with a member who meets the definition of elderly in B-431, Definition of Elderly, or of having a disability in B-432, Definition of Disability, if the:

- member who is elderly or has a disability incurred the expense; and
- medical expenses exceed $35 a month. If two or more people in the household qualify for a medical deduction, combine the medical expenses. If an applicant has been or will be reimbursed for a medical expense, deduct only the nonreimbursed amount.

Expenses that the household is still legally obligated to pay are allowed for someone who was a household member:

- immediately before entering the hospital or nursing home; or
- when the member died.

A-1428.1 Allowable Medical Expenses

Revision 25-2; Effective April 1, 2025

SNAP

Deductions are allowed for the following medical expenses:

- medical care provided by a licensed practitioner or other qualified health professional, including a registered dietician;
- dental care provided by a licensed practitioner or other qualified health professional;
- psychotherapy care provided by a licensed practitioner or other qualified health professional;
- rehabilitation care provided by a licensed practitioner or other qualified health professional;
- hospitalization provided by a facility recognized by the state;
- outpatient treatment provided by a facility recognized by the state;
- nursing care provided by a facility recognized by the state;
- nursing home care provided by a facility recognized by the state;
- diapers for children with disabilities;
- incontinence pads for the elderly or adults with disabilities;
- drugs prescribed by a licensed practitioner, including insulin;
- over-the-counter medication, including aspirin, ibuprofen, and medicated creams, when approved by a licensed practitioner or other qualified health professional;
- medical supply costs, including rental costs, are deductible with a prescription or approval;
- sickroom equipment costs, including rental costs, are deductible with a prescription or approval;
- adaptive aids;
- health insurance policy costs, including dental insurance and vision insurance costs;
- hospitalization insurance policy costs, including hospital indemnity insurance costs;
- Medicare premiums, cost-sharing and deductibles;
- Spend Down expenses incurred by Medicaid recipients;
- Medicaid Buy-In for Children (MBIC) premium payments;
- dentures;
- hearing aids;
- prostheses;
- service animal costs, including the costs of securing, maintaining, feeding, and visiting the veterinarian for any animal trained to serve the needs of a person with disabilities, such as a guide dog or dog to help the hearing impaired;
- eyeglasses prescribed by a qualified health professional;
- lodging costs to obtain medical services;

- care costs, including the costs of maintaining an attendant, home health aide, child care provider or housekeeper necessary because of age or illness. If the household furnishes most of the attendant's meals, also include a deduction equal to the allotment for a one-person SNAP household. If the household has attendant care costs that could qualify under both medical and dependent care deductions, consider the cost a medical expense;
- repayment of a loan used to pay medical expenses; or
- transportation costs, including trips to the doctor, hospital, therapy, drug store, or paying someone to drive the person for medical services.

Note: When determining transportation costs, the person may choose to use 70 cents per mile instead of keeping track of actual expenses.

Deductions are not allowed for the following medical expenses:

- the costs of policies that do not specifically cover medical costs such as income maintenance or lump sums for death or dismemberment;
- food supplements that can be purchased with SNAP, such as Ensure and baby formula, even if prescribed by a physician;
- paid or past due expenses billed before the initial certification period, meaning before the person was receiving SNAP;
- medical marijuana, even if prescribed by a physician; or
- herbal products which are a form of dietary supplements derived from plants used to improve or maintain one's health which usually do not require a prescription, including:
  - melatonin;
  - valerian root;
  - echinacea;
  - flaxseed;
  - ginseng;
  - ginkgo;
  - St. John's wort and;
  - garlic.

Related Policy

Income, A-1300

A-1428.2 Budgeting Medical Deductions

Revision 24-2; Effective April 1, 2024

SNAP

Households that have a member who is eligible for a medical expense are eligible for a deduction using either the standard medical expense (SME) or actual medical expenses.

At	then verify	and budget
application, if the household has medical expenses over $35 and $170 or less a month,	the household has medical expenses over $35,	the SME.
application, if the household has medical expenses over $170 a month,	actual medical expenses,	• actual monthly medical expense amount, if the household provides verification of medical expenses over $170; or • the SME, if verified medical expenses are over $35 and $170 or less. If the household does not provide verification of medical expenses, do not allow a deduction $170, then allow the SME instead of actual.
redetermination, if: • the household already has medical expenses over $35 and $170 or less; and • there is no change, or the amount changed but the monthly medical expense is still over $35 and $170 or less,	no additional verification is required,	the SME.
redetermination, if SNAP budget does not already include the SME and the household states an eligible	the household has medical expenses over $35,	the SME.

At	then verify	and budget
member has medical expenses over $35 and $170 or less,		
redetermination, if SNAP budget does not already include actual medical expenses and the household states an eligible member has medical expenses over $170,	actual medical expenses,	• actual monthly medical expense amount, if the household provides verification of medical expenses over $170; or • the SME, if verified medical expense is over $35 and $170 or less. If the household does not provide verification of medical expenses, do not allow a deduction.
redetermination, if: • the household has actual medical expenses over $170 already budgeted, and • there is over a $25 change in the monthly amount,	the change in medical expenses,	• the SME if the new total is over $35 and $170 or less; or • actual medical expenses if the new total is over $170.

When the medical expense ends, staff must end-date the medical expense record in TIERS.

TIERS automatically subtracts $35 from the SME or actual medical expenses to determine the net amount of the medical deduction.

If a member is disqualified for:

- SNAP Employment and Training (E&T), a felony drug conviction, IPV, refusal to cooperate with the quality control review process, or being a fugitive, and is billed for or pays medical expenses — the full deduction is allowed; or
- SSN noncompliance, citizenship requirements, alien status, or the ABAWD work requirement, and is billed for or pays medical expenses for the disqualified member's own expenses or the medical expenses of another household member who is elderly or has a disability — the expense or the standard medical deduction is prorated among all household members and the pro rata share for people disqualified for SSN noncompliance, citizenship requirements, alien status, or the ABAWD work requirement is not allowed. The full medical deduction is allowed if the medical expenses are paid by an eligible household member.

If the disqualified person has the only income, the medical expenses are considered paid by the only person with income.

The following information describes how the SME or actual medical expenses are prorated in the event a disqualified member pays for some or all the allowable medical expenses.

Eligibility for the SME or actual medical expenses is determined based on verified medical expenses of all aged members or members with disabilities, including a disqualified member. The SME is used if the total verified medical expenses are over $35 and l $170 or less. The household may claim actual expenses if the total verified expenses are over $170.

If	then	and
the household is eligible for the SME,	prorate the SME among all household members,	use the eligible household members' portion of the SME in the budget. In TIERS, enter the amount each member actually pays, and TIERS prorates accordingly.
the household is eligible for actual medical expenses,	prorate the portion paid by the disqualified member among all household members,	add the eligible household members' prorated portion to the actual amount of medical expenses any eligible member pays and use this amount in the budget. In TIERS, enter the amount each member actually pays, and TIERS prorates accordingly.

Example 1 (SME): The household consists of three eligible members with total verified monthly medical expenses of $75 and one member who is disqualified due to citizenship. The disqualified person pays for half of the medical expenses, and an eligible person pays for the other half. The household is eligible for the SME because the total verified monthly medical expenses are $75, which is more than $35 but less than $170. The SME is prorated among the eligible members because the disqualified member pays for part of the medical expenses.

$170 / 4 = $42.50
$42.50 x 3 = $127.50

In TIERS, a medical expense of $37.50 ($75 divided by 2) is entered for both the disqualified person and for the eligible member, which is the amount of monthly medical expenses each member actually pays, and TIERS will budget a prorated SME of $127.50.

Example 2 (Actual Medical Expenses): The household situation is the same as Example 1, except that the monthly amount of verified medical expenses is $200. The disqualified member pays $100 of the medical expenses. The household is eligible for the actual amount of

medical expenses. The amount the disqualified member pays is prorated and added to the portion paid by the eligible member to determine the total amount of the medical deduction.

$100 / 4 = $25
$25 x 3 = $75
$75 + $100 = $175

The following amounts are entered in TIERS:

- $100, for the eligible member; and
- $100, for the disqualified member and TIERS will prorate the allowable amount to $75.

Finally, TIERS automatically subtracts $35 from the total deduction to determine the net amount of the medical deduction.

A-1428.2.1 Determining Allowable Costs for Individuals with a Medicare Prescription Drug Plan Part D

Revision 15-4; Effective October 1, 2015

SNAP

If the applicant is enrolled in Medicare Drug Plan Part D, the individual's prescription costs are budgeted following normal rules by reasonably anticipating the individual's unreimbursed out-of-pocket expenses.

Note: The household may opt for the SME.

A-1428.3 Budgeting Options

Revision 21-4; Effective October 1, 2021

SNAP

When averaging the medical expenses, the SME is budgeted for each month of the certification period, as long as the household's allowable averaged monthly medical expense is greater than $35. If the expense recurs monthly or more often, and the medical expense exceeds $35 and is less than or equal to $170 a month, the SME is budgeted for each month of the certification period. When allowable medical expenses for the household exceed the SME, the actual medical expenses are budgeted. The following chart is used to determine when to budget the SME or actual medical expenses.

If the expense ...	then budget the ...
recurs less often than monthly and the amount averaged for each month is less than or equal to $35,	actual amount of verified actual medical expense in the month billed, or use the SME in the month billed if the medical expense is greater than $35 and less than or equal to $170.
recurs less often than monthly and the amount averaged for each month is greater than $35 and less than or equal to $170 a month,	SME for each month of the certification period.
recurs less often than monthly and the amount averaged for each month is greater than $170,	averaged amount of actual verified medical expenses for each month. Budget the SME only if the household chooses to use the SME or fails to provide enough verification to qualify for actual medical expenses.
occurs one time and the amount averaged over the certification period is less than or equal to $35 a month,	actual amount of verified medical expenses in the month billed, or use the SME in the month billed if the medical expense is greater than $35 and is less than or equal to $170.
occurs one time and the amount averaged over the certification period is greater than $35 and less than or equal to $170 a month,	SME for each month of the certification period.
occurs one time and the amount averaged over the certification period is greater than $170 a month,	averaged amount of the actual medical expenses for each month. Budget the SME only if the household chooses to use the SME or fails to provide enough verification to qualify for actual medical expenses.

Note: A deduction is allowed for payments made on a monthly payment plan set up before the expense became past due.

A-1428.4 Change in Medical Expenses During Certification

Revision 15-4; Effective October 1, 2015

SNAP

SNAP households are not required to report changes in medical expenses during the certification period.

Households should be advised that a new one-time expense or change in a recurring medical expense that is reported and verified timely may be budgeted in the certification period.

If the household voluntarily reports a change in medical expenses and the change is reported and verified timely, the advisor must consider the newly reported change to determine if the individual should consider switching from the SME to actual expenses.

A medical expense, paid or unpaid, is reported timely if it is reported before it becomes past due to the provider:

- anytime during the certification period, or
- at the next redetermination.

A one-time medical expense reported and verified too late to budget in the current certification period may be deducted in the first month of the next certification period or averaged over the next certification period.

When the household timely reports and provides timely verification of a paid or unpaid expense (one-time medical expense or recurring) at the redetermination interview:

- the expense is deducted in the first month of the new certification period, or
- averaged over the new certification period.

When a change in medical expenses is reported during the certification period by a ...	then ...
household member or the authorized representative,	follow the procedures in B-600, Changes, for both increases and decreases in benefits.
source other than a household member or the authorized representative,	act on the change if it is considered to be verified at the time of receipt and the change can be made without contacting the household for additional information or verification. **Note:** If the change would require contact with the household, do not act on the change until the household is recertified.

A-1428.5 Switching Between Actual Medical Expenses and the Standard Medical Expense

Revision 15-4; Effective October 1, 2015

SNAP

Households may switch between actual expenses and the SME at redetermination. Households may also switch at an incomplete review if changes in medical expenses are reported and it is to the household's advantage to switch from the SME to actual medical expenses.

A-1429 Shelter Costs

Revision 24-4; Effective Oct. 1, 2024

SNAP

A deduction is allowed for all households that incur a shelter cost using the following rules:

- Households may deduct monthly shelter costs that exceed 50 percent of the income remaining after other deductions.
- The shelter deduction cannot exceed the maximum unless there is a member of the household who is elderly or has a disability. Household members who are disqualified for another reason are eligible for the uncapped excess shelter deduction when there is a member of the household who is elderly or has a disability.
- A deduction is allowed only for charges for the shelter the household currently occupies. **Exceptions:**
  - If a required household member is employed in another city and maintains a residence there, shelter costs are allowed for both the regular residence and the residence maintained where the member is employed. The household may claim one of the utility allowances.
- Households sharing shelter costs are both entitled to a shelter deduction for their share.
- Shelter costs paid by an exempt vendor payment or reimbursement are not deductible. **Exception:** A deduction for utility costs is allowed.
- One of the utility allowances or standards is allowed.
  Note: The utility and telephone standards for households with disqualified members or households sharing utility costs must not be

prorated.
- Property taxes that are averaged are deducted, even if the cost is paid or past due when reported.

An uncapped excess shelter deduction is **not** allowed for households with members who:

- are disqualified for not meeting SSN requirements or alien status requirements;
- have reached the Able-Bodied Adult Without Dependents (ABAWD) federal time limit; or
- only receives a medical deduction for a former household member.

Related Policy

Rules that Apply to Deductions, A-1411
Households with Elderly Members or Members with a Disability, B-430
Special Provisions for Households with Elderly Members or Members with a Disability, B-433
Deduction Amounts, C-121.1

A-1429.1 Allowable Shelter Costs

Revision 24-1; Effective Oct. 1, 2024

SNAP

Allowable costs include rent, mortgage payments and other continuing charges leading to ownership of the property, such as mandatory maintenance and homeowner association fees.

Consider the following when determining if the shelter cost is allowable:

- For mortgage payments, an amount that goes into an escrow account is part of the total allowable cost of the mortgage payment. Do not allow another separate deduction for shelter costs paid from an escrow account. **Example:** If property taxes are paid from the escrow account, do not allow property taxes as a separate deduction.
- Costs to repay a loan are allowable shelter costs only if the lender places a lien on the property because of the loan. The loan may be for home repair or improvement, or for purposes unrelated to the home, but the payments due are considered a mortgage if the loan results in a lien on the property.
- Maintenance fees must be mandatory as a condition for the continuation of residence for renters and homeowners. The fees must be a required fee payment, not a requirement to maintain the property.
- Taxes and insurance on the shelter, but not its contents, are allowed. The cost of insurance for the shelter and the contents are allowed if they cannot be separated.
- The cost of mandatory renter's insurance is allowable, regardless of what the insurance covers, provided the renter's insurance is a requirement of the tenant's lease.
- Charges for fuel, utilities, sewage and garbage collection are used to determine if the household may be eligible for one of the utility allowances.
- Costs related to phone service, including a mobile phone, are used to determine if the household may be eligible for the phone standard deduction.
- Unreimbursed costs for the repair of a home damaged by a natural disaster are allowed.

Note: Shelter costs do not include one-time deposits.

Related Policy

Deduction Amounts, C-121.1

A-1429.2 Shelter Deductions for an Unoccupied Home

Revision 24-4; Effective Oct. 1, 2024

SNAP

The actual shelter costs are budgeted for a home excluding utility costs that is unoccupied because of employment or training, illness, including receiving medical treatment, natural disaster or casualty loss such as fire, flood or state of disrepair, if the:

- household intends to return to the home;
- current occupants are not claiming the same shelter costs the owner is claiming for SNAP purposes; and
- home is not leased or rented.

The household may claim both the shelter costs of its current home and the cost of the unoccupied home, and a single utility standard, if eligible for one, but no more than the maximum excess shelter deduction, if applicable.

A-1429.3 Utility Allowances

Revision 24-4; Effective Oct. 1, 2024

SNAP

The appropriate utility allowance is determined at application, redetermination and when the household reports a change in utility costs.

Related Policy

Change in Address, B-639

A-1429.3.1 Standard Utility Allowance (SUA)

Revision 24-4; Effective Oct. 1, 2024

SNAP

The SUA is budgeted for households that:

- have or anticipate out-of-pocket heating or cooling costs separate from their rent or mortgage payments during the next 12 months; or
- have received a Low Income Home Energy Assistance Program (LIHEAP) payment or other similar energy assistance payment of more than $20 annually in the previous 12 months or in the current month.

No other deductions related to utilities are allowed when using the SUA.

Notes:

- Cooling costs are limited to the cost related to the operation of an air conditioning system, an evaporative cooler or swamp box or window unit air conditioner(s). A fan is **not** considered a cooling cost for the purposes of qualifying for the SUA.
- Each household is eligible for the SUA when they share heating or cooling costs and a meter, whether they live together or not.

Related Policy

Deduction Amounts, C-121.1

A-1429.3.2 Basic Utility Allowance (BUA)

Revision 24-4; Effective Oct. 1, 2024

SNAP

The BUA is budgeted, for households that incur utility costs other than a phone but do not have heating or cooling costs separate from their rent or mortgage payments. No other deductions related to utilities are allowed when using the BUA.

Each household is eligible for the BUA when they share utility costs other than a phone but do not have heating or cooling costs, whether they live together or not.

Related Policy

Deduction Amounts, C-121.1

A-1429.3.3 Determining the Appropriate Utility Allowance

Revision 24-4; Effective Oct. 1, 2024

SNAP

Use the following chart as a guide to determine the appropriate utility allowance the household is eligible to receive.

If the person	then the household is eligible for the
owns or is buying their home and is billed for utilities that include heating or cooling costs,	SUA.

If the person	then the household is eligible for the
owns or is buying their home and is billed for utilities that do **not** include heating or cooling costs, **Example:** The household does not have air conditioning and cools their home with fans and uses a cooking stove for heating.	BUA.
receives LIHEAP payments or other similar energy assistance payments more than $20 annually in the previous 12 months or in the current month,	SUA.
rents and is billed for utilities from an individual meter for heating or cooling costs,	SUA.
rents from a landlord who lives in a separate residence and the landlord bills the household a standard amount for the heating and cooling costs,	SUA.
lives in public housing and is billed only for excess heating or cooling costs,	SUA.
shares the cost and a meter with another household who lives in a separate residence on the same property and the other household is billed for the utilities that include heating and cooling costs,	SUA.
lives together at the same residential address with a friend or family member and the person: • shares the heating or cooling costs with the friend or family member, even if the friend or family member is billed for the utilities that include heating and cooling costs; • pays the cooling bill and the friend or family member pays the heating; or • pays the friend or family member a set amount for the utilities that include heating or cooling costs separate from the rent,	SUA.
lives together at the same residential address with another household and the person shares the utility costs that do not include heating or cooling costs separate from the rent,	BUA.
lives together at the same residential address with another household who pays for the heating and cooling costs and the person is only responsible for the water bill,	BUA.
pays only the phone costs and all other utility costs are included in the shelter costs,	telephone standard.
lives together at the same residential address with other households who share the heating, cooling or other utility costs and the person is only responsible for the phone bill,	telephone standard.
lives with a disqualified member and the household pays heating or cooling costs,	SUA.
lives with a disqualified member and the household pays non-heating or non-cooling costs,	BUA.

A-1429.4 Telephone Standard

Revision 25-4; Effective Oct. 1, 2025

SNAP

The telephone standard is budgeted for households that have a phone cost. This includes a mobile phone, and does not claim the BUA, SUA or the homeless shelter standard.

Related Policy

Deduction Amounts, C-121.1

A-1430, Standard Deduction

Body

A—1430 Standard Deduction

Revision 15-4; Effective October 1, 2015

SNAP

The standard deduction is budgeted as shown in C-121.1, Deduction Amounts, for each household.

Medical Programs except TP 45

All households receive the standard MAGI income disregard listed in C-131.4, Standard MAGI Income Disregard, by MAGI household size. This disregard is equal to five percentage points of the Federal Poverty Income Limit (FPIL) and is applied when calculating MAGI household income, as explained in A-1341, Income Limits and Eligibility Tests, Medical Programs, Step 4.

A-1440, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

All Programs except TP 45

If an individual fails to provide a required verification of a deduction, do not deny the EDG. Disallow the deduction. If the individual subsequently provides verification of the deduction, use report of change guidelines to budget the deduction.

TANF

Dependent care must be verified at application, complete review, or if the amount changes.

The following amounts must be verified at application, complete review, or if the amount changes:

- actual amount of child support and alimony paid to persons outside the home, and
- actual amount of payment to persons outside the home whom a person can claim as tax dependents or is legally obligated to support.

SNAP

Dependent care expenses must be verified at application, recertification, and when the individual reports a change in dependent care if verification can be obtained during the interview. If verification cannot be obtained during the interview, the individual's statement may be accepted without verification if the household states the total dependent care expense for the EDG does not exceed $300 a month and it is not questionable. The EDG is pended only if the expense claimed is questionable or exceeds a total of $300 a month.

The following amounts must be verified:

- household's legal obligation to pay child support:
  - by viewing a court order, administrative order, legally enforceable separation agreement, other official document; or
  - using a collateral contact with access to an official document.
- amount of the child support obligation.
- actual amount of child support paid by viewing:
  - Attorney General or county registry collection and distribution records,
  - canceled checks,
  - wage withholding statements,
  - withholding information from unemployment compensation, or
  - statements from the custodial parent regarding direct payments or third-party payments the household pays or expects to pay on behalf of the custodial parent.

  Note: Documents used to verify the household's legal obligation to pay child support are not acceptable verification of the household's actual payments.
- medical expenses. See A-1428.2, Budgeting Medical Deductions.
- rent or mortgage costs if the expense is questionable or if a regional requirement. If the requested proof is not provided, the expense is not allowed.
- shelter cost of an unoccupied home at initial application, changes, and recertifications.

Medical Programs except TP 45

All MAGI expenses must be verified at application, complete review, or if the amount changes.

A—1441 Verification Sources

Revision 20-2; Effective April 1, 2020

TANF and SNAP

Dependent Care

- statement or a current bill from provider;
- current receipts; or
- previous year's income tax return.

Child Support Paid by Household – Verifying Amount of Child Support Paid

- attorney general collection and distribution records;
- county clerk records;
- cancelled checks;
- wage withholding statements;
- withholding statements from unemployment compensation; or
- statement from the custodial parent regarding direct payments or third-party payments paid on their behalf.

TANF and Medical Programs except TP 45

Alimony Amount

- divorce decree;
- separation agreement;
- court order;
- court records; or
- statement from the person who is receiving the alimony.

TANF

Dependents Outside the Home

- previous year's tax records;
- bank records;
- copies of money orders;
- cancelled checks; or
- statement from the person who is receiving the payments.

SNAP

Medical Expenses

- bills (or copies of bills) from providers of health insurance, services and products;
- statement or a current bill from providers;
- health insurance policies;
- statement from a qualified health professional indicating that over-the-counter medication, medical equipment or supplies are prescribed; or
- State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to verify Medicare Part B premiums.

Note: If the person receiving SNAP is covered by insurance, the statement from providers needs to show the balance due after insurance pays.

Child Support Paid by Household – Verifying Legal Obligation

- court order;
- administrative order;
- legally enforceable separation agreement;
- divorce decree;
- attorney general child support enforcement records; or
- county clerk records.

Mortgage

- statement from mortgage company or bank;
- cancelled checks; or

- mortgage receipt.

Rent

- statement from landlord or apartment manager;
- rent receipt;
- cancelled checks; or
- current lease contract showing the payment amount. **Note:** A common practice of leasing companies is to show the monthly market amount on the first page of a lease, not the actual payment amount of the lease.

Property Taxes

- tax bill;
- cancelled check;
- statement from tax office employee; or
- county tax office websites.

Home Insurance

- insurance company bill;
- cancelled check; or
- statement from an insurance company employee.

Utilities

- utility company bill;
- cancelled checks; or
- statement from utility company employee.

Medical Programs except TP 45

An applicant's or recipient's federal income tax return from the previous year is the only valid verification source that can be used to verify all MAGI expenses except for alimony paid.

Note: A federal income tax return from the previous year is valid verification for MAGI expenses until the client files a new federal income tax return but no later than April 15 or the official tax filing day of the following year. If a person files an extension and submits proof of an extension, such as a copy of IRS Form 4868, the previous year's federal income tax return is valid until Oct. 15. If an applicant or recipient does not file federal income taxes, they will not be able to provide verification and, therefore, will not be able to claim any MAGI expenses other than alimony paid.

Date of Divorce or Separation Agreement for Alimony Paid

- divorce decree;
- separation agreement;
- court order; or
- court records.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A-1450, Documentation Requirements

Body

Revision 24-4; Effective Oct. 1, 2024

All Programs except TP 45

Document:

- the type of deduction allowed;
- the person for whom a deduction is allowed and how the person qualifies;
- the source or provider to whom a deduction expense is paid including their name, address or phone number;
- date and amounts paid; and
- calculations used to determine monthly amounts.

TANF and SNAP

Document:

- the reason a household qualified for a dependent care deduction when it is questionable or not obvious; and
- justification for not allowing earned income deductions.

TANF

Document the relationship of the child care provider to the child.

SNAP

Document when the household:

- choses the Standard Medical Expense (SME) and their expenses exceed the SME;
- does not qualify for a utility standard deduction; and
- includes one of the utility standard deductions such as the standard utility allowance, basic utility allowance and phone standard in their budget.

Exception: Utility service providers' names and addresses are not required documentation.

Medical Programs except TP 45

Document the date the person's divorce or separation agreement was executed or modified for alimony paid.

A-1500, Reminders

A-1510, General Reminders

Body

Revision 23-2; Effective April 1, 2023

All Programs

Before certifying applicants and recertifying recipients, staff must:

- Ensure that the applicant completes each item and signs and dates the application or renewal form. **Note:** If the applicant indicates changes during the interview, or application or renewal processing, document the nature of the change and when the person expects the change to occur. People on TP 08, TP 43, TP 44 and TP 48 complete the administrative renewal process and may not be required to provide a signed renewal form.
- Give the applicant Form H1019, Report of Change. Explain the applicant must report changes within 10 days after the household knows about the change. Indicate the appropriate reporting requirement on page 1.
- Refer the applicant to other programs the applicant might be eligible for, such as:
  - family planning;
  - Supplemental Security Income (SSI);
  - Women, Infants and Children (WIC); and
  - Social Security.
- Refer people who are elderly or have disabilities and who are ineligible for Medical Programs for families and children to the Texas Health and Human Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) programs. **Note:** If a person indicates they need services that Texas Works does not offer, and HHSC staff cannot provide a resource number, advise the person to call 2-1-1, option 1, for information and referral services.
- Inform the applicant of the right to appeal any HHSC action that affects the applicant's eligibility or amount of benefits.
- Check for unpaid overpayments from prior certifications.
- Inform applicants that the information they provide is subject to verification by third parties.

Related Policy

Medical Program Administrative Renewals, B-122.4

TANF

Staff must:

- Explain federal and state time limits of Temporary Assistance for Needy Families (TANF) benefits.
- Inform the person that a Choices noncompliance penalty makes them ineligible for a TANF state time limit hardship exemption during their five-year freeze-out period.
- Explain members need to be employed or apply for other sources of income. Encourage individual independence.
- Explain the requirement to seek other income available to the person, as explained in the policy related to pursuing SSI and RSDI benefits. Provide the document, Social Security Administration Benefits for People with Disabilities Receiving TANF (English PDF or Spanish PDF). Explain that the person must apply for applicable benefits and provide verification by the next TANF redetermination.
- Explain the option to receive One-Time TANF (OTTANF) instead of TANF. Offer this option to households eligible for TANF but not currently receiving TANF.
- For relatives who are potentially eligible to receive One-Time TANF for Relatives, explain the option to receive this additional benefit for a related dependent child certified for TANF.
- Inform people receiving a TANF one-time payment that they will receive the payment through the mail in the form of a warrant (check) and that the U.S. Postal Service does not forward TANF warrants. The address on file with HHSC must match the address on file with the U.S. Postal Service.
- Inform people with a Choices noncooperation, who reapply for TANF while in pay for performance, to contact the local Workforce Solutions office within 10 days. This allows enough time to demonstrate 30 days of cooperation before the 40th day after the interview date.

Related Policy

Requirement to Pursue SSI/RSDI, A-1311.1
ASSI/RSDI Application Assistance, A-1311.1.1
Open Penalty at Reapplication in Pay for Performance, A-2151
One Time Payments, A-2400

SNAP

Staff must:

- Explain the Employment and Training (E&T) program requirements and services to applicable households at application and redetermination.
- Explain the Supplemental Nutrition Assistance Program (SNAP) time limits to people subject to these limits.
- Give Form H1805, SNAP Food Benefits: Your Rights and Program Rules, to all households at application and redetermination. Respond to any questions the applicant has about the form.
- Give Form H1019 to all streamlined reporting households. Indicate the appropriate reporting requirement on page 1. Explain streamlined reporting households must:
  - Report changes in residence, and associated changes in shelter costs, and when their ongoing gross income exceeds 130 percent of the Federal Poverty Limit (FPL) for the household size.
  - Report changes within 10 days after the household knows of the change.
  - Respond to all notices and letters from the Employment and Training program as directed, even if they are employed.

Related Policy

What to Report, B-621

TP 43, TP 44 and TP 48

Staff must:

- Mail form VR30, Texas Voter Registration Application, with the initial eligibility notice to a newly certified family and at subsequent redeterminations.
- Inform the family that when HHSC processes an application and determines the child is ineligible for Medicaid but eligible for the Children's Health Insurance Program (CHIP), the family is notified on Form TF0001, Notice of Case Action. Form TF0001 also informs the household that the CHIP enrollment packet will be sent to the household.
- Inform new caretakers about the requirement to participate in a health care orientation. Include Form TF0001. This one-time requirement applies only to caretakers who have not been included as a certified or budget group member of a Medical Programs Eligibility Determination Group (EDG) within the past two years.
- Inform caretakers of Medicaid children under 19 that they are required to comply with the regimen of care prescribed by the Texas Health Steps program. The requirement applies to children starting at 2 years old. Begin checking for compliance with the first redetermination after the caretaker is informed of the requirement.

Related Policy

Registering to Vote, A-1521

A-1520, Registering to Vote

Body

A-1521 Registering to Vote

Revision 15-4; Effective October 1, 2015

All Programs

HHSC must offer individuals an opportunity to register to vote at application, redetermination and any time the individual has a change of address. The individual is provided with form VR30, Texas Voter Registration Application, with each application/redetermination packet, if not already provided. Additionally, the individual will be provided with VR30 whenever the individual reports a change of address. System-generated application and redetermination packets contain VR30.

If the individual declines the opportunity to register to vote, the individual is given Form H1350, Opportunity to Register to Vote, to sign and decline to register to vote. Advisors should indicate in the Texas Integrated Eligibility Redesign System (TIERS), Voter Registration Information section of the Individual Demographics page, that the individual declined and document that Form H1350 was mailed to the individual. When the individual returns Form H1350, advisors are to send the form for imaging. The imaged, signed form must be retained for at least 22 months. The individual is not required to sign Form H1350 if the individual has signed the form within the last 22 months.

A-1521.1 Who Cannot Register to Vote

Revision 15-4; Effective October 1, 2015

All Programs

To register to vote, a person must be:

- a U.S. citizen; and
- at least age 17 years and 10 months.

Staff should not offer a voter registration application to an applicant or recipient if the individual states or the advisor has proof that the individual does not meet these two requirements.

A-1521.2 Staff Requirements for Voter Registration

Revision 15-4; Effective October 1, 2015

All Programs

Staff must tell the individual the following:

- HHSC will offer the same help and services when aiding the individual with voter registration activities as when aiding the individual with agency forms, whether HHSC provides the service in the office, outside of the office or at the individual's home.
- The decision to register or to decline to register to vote does not affect eligibility or benefit amount, and HHSC will keep all voter registration information confidential and only use it for voter registration purposes.
- The individual may decide whether or not to seek help from staff to fill out the voter registration application form, or the individual may fill out the application form in private.
- The individual may return the completed application form to:
  - the Secretary of State (SOS), by mail using the postage-paid, self-addressed application form;
  - the local voter registrar, by mail or in person; or
  - the advisor.
- The individual may ask additional voter registration questions or file a voter registration complaint by contacting the Elections Division of the Secretary of State, P.O. Box 12060, Austin, TX 78711, 1-800-252-8683.

Staff must not:

- influence an individual's political preference or party registration;
- display any political preference or party affiliation;
- make any statement to discourage the individual from registering to vote;
- make any statement to an individual or take any action for the purpose or effect to make the individual believe that a decision to register or not to register has any bearing on the availability of services or benefits; or
- pend the EDG or delay or deny benefits if the individual fails or refuses to complete the voter registration information on any form, or fails to return VR30, Texas Voter Registration Application, or Form H1350, Opportunity to Register to Vote.

Austin Imaging Center Staff

If the individual inadvertently sends VR30 to the Austin processing center with other documents, Austin staff will forward VR30 to the correct local voter registrar within five days of receipt.

A-1521.3 Voter Registration During Interviews

Revision 15-4; Effective October 1, 2015

All Programs

The following chart should be used by staff in addressing voter registration during the interview:

If …	then …
	determine the reason why the individual doesn't wish to register. Ask the individual to sign Form H1350, Opportunity to Register to Vote, attesting that the individual does not wish to register to vote. Sign and mark the appropriate box in the Agency Use Only: Voter Registration Status section of Form H1350 documenting the reason the individual declined to register. Send the form for imaging.
the individual responds, "I do not wish to register,"	When completing a telephone interview, mail Form H1350 to the individual. Indicate in TIERS, Voter Registration Information section of the Individual Demographics page, that the individual declined and document that Form H1350 was mailed to the individual. When the individual refuses to sign Form H1350, mark the Client Declined box in the Agency Use Only: Voter Registration Status section of Form H1350. Send the form for imaging.
the individual is not a U.S. citizen and at least age 17 years and 10 months,	TIERS will automatically mark that the individual does not meet citizenship and/or age requirements in the Valid Reason, Voter Registration Information section of the Individual Demographics screen.
the individual answered Yes to the question on the application, redetermination or change report form, "Do you wish to register to vote?" and meets citizenship and age requirements,	provide the individual with form VR30, Texas Voter Registration Application, to complete to register to vote. Advise the individual that the completed form can be returned directly to SOS, the local voter registrar or the local office. The local office liaison forwards to the local voter registrar. TIERS automatically sends the individual form VR30 if the worker answers Yes to the question, “Send Voter Registration Application?” in the Voter Registration Information section of the Individual Demographics screen. Enter the actions taken to provide the individual with the opportunity to register to vote by answering the questions in the Valid Reason, Voter Registration Information section of the Individual Demographics screen. When interviewing an authorized representative (AR) or representative payee, ask the AR or representative payee to give the form to the individual. Enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, Client to Mail.
the individual completes and returns form VR30 before leaving the office,	review the form for completeness. Return the form to the individual for any corrections, if necessary. When the individual has fully completed form VR30, forward the form to the local office liaison. The local office liaison will review the form for completeness and send to the local voter registrar within five days. Enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, the actions taken to provide the individual with the opportunity to register to vote.

A-1521.4 Voter Registration During Non-Interviews

Revision 15-4; Effective October 1, 2015

All Programs

The following chart should be used by staff in addressing voter registration during non-interviews:

If …	then …
the individual "does not wish to register" on the application/redetermination or change report form,	mail the individual a return envelope and Form H1350, Opportunity to Register to Vote, to sign attesting that the individual declined to register to vote. Enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen. If the individual returns Form H1350, sign and mark the Client Declined box in the Agency Use Only: Voter Registration Status section of Form H1350. Send the form for imaging.
the individual is not a U.S. citizen and at least age 17 years and 10 months,	TIERS automatically marks that the individual does not meet citizenship and/or age requirements in the Valid Reason, Voter Registration Information section of the Individual Demographics screen.
the individual answered Yes to the question on the application/redetermination form, "Do you wish to register to vote?",	• if the individual did not return form VR30, Texas Voter Registration Application, enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, the actions taken to provide the individual with the opportunity to register to vote. • when the individual returns form VR30 to the local office, review the form for completeness. Return the form to the individual for any corrections, if necessary. Enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, the actions taken to provide the individual with the opportunity to register to vote. Forward the fully completed form VR30 to the local office liaison. The local office liaison reviews the form for completeness and sends to the local voter registrar within five days.
the individual answered Yes to the question, "Do you wish to register to vote?" on the change report form,	Enter Yes to the question, "Send Voter Registration Application?" in the Voter Registration Information section of the Individual Demographics screen. TIERS automatically sends the individual form VR30. This documents the actions taken to provide the individual with the opportunity to register to vote.

A-1521.5 Local Office Liaison Duties

Revision 15-4; Effective October 1, 2015

All Programs

The local office liaison must:

- Maintain in stock, the office supply of form VR30, Texas Voter Registration Application, and Form H1350, Opportunity to Register to Vote.
- Maintain the local voter registrar list to provide the name and address of the local voter registrar to staff and individuals. See www.sos.state.tx.us/elections/voter/county.shtml for information regarding the local voter registrar.
- Review form VR30 for completeness.
- Send completed form VR30 to the designated local voter registrar within five days of receipt.

A-1521.6 Documentation

Revision 15-4; Effective October 1, 2015

All Programs

All actions taken to provide the individual with an opportunity to register to vote must be documented at application, redetermination, and change of physical address in TIERS in the Voter Registration Information section of the Individual Demographics — Citizen page.

A-1522 Personal Responsibility Agreement

Revision 19-3; Effective July 1, 2019

TANF

Staff must inform adult caretakers and second parents that they must:

- participate in the Choices programs unless exempt;
- cooperate with child support requirements;

- not voluntarily quit a job;
- have their child(ren) screened through the Texas Health Steps program;
- have their child(ren) immunized, unless exempt;
- have their child(ren) attend school;
- attend parenting skills training, if referred; and
- not abuse drugs or alcohol.

Staff must inform payees and disqualified adults that they must:

- cooperate with child support requirements;
- have their child(ren) screened through the Texas Health Steps program;
- have their child(ren) immunized, unless exempt;
- have their child(ren) attend school; and
- not abuse drugs or alcohol.

A-1523 Child Support Responsibilities

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Staff must ensure that applicants read and understand the information on Form H1712, Explanation of Child/Medical Support, Family Violence and Good Cause, and that the applicant understands that signing an application for TANF or TP 08 constitutes the assignment of rights to child and medical support.

A-1524 Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

Staff must inform the applicant that if the individual goes to work and reports the job in a timely manner, the individual may be eligible for extra deductions.

A-1525 Voluntary Quit

Revision 15-4; Effective October 1, 2015

SNAP

Staff must explain the voluntary quit policies in A-1850, Voluntary Quit, to applicants and individuals, including:

- primary wage earner determination;
- how to establish good cause; and
- reapplication after voluntary quit.

A-1526 Family Violence

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Staff must explain to applicants and recipients that if family violence or the potential for family violence exists, HHSC may grant an exemption from the requirement to cooperate with child support, and Choices staff may grant good cause for noncompliance with Choices participation for TANF.

Related Policy

Explanation of Good Cause, A-1130
Determining Good Cause, A-1860

A-1527 The Texas Works Message

Revision 15-4; Effective October 1, 2015

TANF

During the redetermination process, staff deliver the Texas Works message to TANF recipients explaining that:

- TANF is temporary and has time limits;
- there are alternatives and options for the recipient instead of TANF benefits;
- a TANF recipient should consider jobs and other resources such as child support rather than continuing TANF;
- if a TANF recipient chooses to continue receiving assistance, the recipient is requesting help finding a job; and
- if a TANF recipient chooses not to continue receiving assistance, the recipient may still qualify for medical assistance and SNAP to support employment while working toward self-sufficiency.

Judgment must be used when deciding which messages are appropriate for a particular recipient.

A-1528 Handbooks

Revision 13-2; Effective April 1. 2013

A-1528.1 Availability of Handbooks for Client Review

Revision 13-2; Effective April 1, 2013

All Programs

A *Texas Works Handbook* is available for review upon request. Individuals may view an electronic version of the handbook. All sections of the handbook must be easily accessible to the individual.

A-1529 Interactive Voice Response (IVR) System

Revision 13-2; Effective April 1, 2013

All Programs

Eligibility staff must review and understand information currently available to individuals through 2-1-1 and encourage individuals to use the self-service options. Encouraging individuals to use the self-service options will help reduce workload in local offices. Individuals can get answers to basic questions 24 hours a day, seven days a week through the automated phone system, the IVR.

Additional information can be accessed by visiting the Texas Health and Human Services Commission, "How to Get Help" website at hhs.texas.gov/services/safety/2-1-1-disaster-assistance.

The 2-1-1 Texas Finding Help In Texas job aid describes how an individual accesses various types of information via the 2-1-1 IVR System.

A-1530, Medical and Dental Benefits

Body

Revision 07-1; Effective January 1, 2007

A-1531 Texas Health Steps

Revision 19-3; Effective July 1, 2019

TP 43, TP 44, TP 45 and TP 48

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's federally-required comprehensive preventive child health service (medical, dental, and case management) for persons from birth through 20 years of age. In Texas, EPSDT is known as Texas Health Steps. Through Texas Health Steps, children and young adults receive regularly scheduled medical and dental checkups. The Texas Health Steps program:

- facilitates early detection and treatment of medical and dental problems;
- provides health supervision for infants; and
- enables persons to establish links with primary health care providers who can meet future needs for care.

Texas Health Steps' mission is to:

- expand the public's and recipients' awareness of existing Texas Health Steps services;
- encourage and increase use of Texas Health Steps services; and
- make comprehensive services available through private and public providers so that infants, children, and adolescents can receive medical and dental care before health problems become chronic and irreversible damage occurs.

Texas Health Steps services comprise the following:

Medical Checkups— Texas Health Steps medical checkups include:

- a comprehensive health and developmental history (including developmental and mental health, nutrition and tuberculosis screenings);
- a complete physical examination;
- laboratory tests (including lead screening);
- routine immunizations;
- health education;
- dental screening and referral to a dentist;
- vision screening;
- hearing screening; and
- referrals to other health care providers as needed.

Texas Health Steps offers checkups according to a recommended schedule. The frequency varies according to the stages of growth. In addition to an inpatient newborn screening, children and young adults may receive up to 29 outpatient checkups. The recommended schedule for periodic medical checkups is:

- Birth to 35 months — 11 health checkups to ensure:
  - proper growth and development; and
  - immunizations are administered according to the Advisory Committee on Childhood Immunization Practices (ACIP) recommended schedule;
- 3 years through 5 years — three health checkups (once a year);
- 6 years through 10 years — five health checkups (once a year); and
- 11 years through 20 years — 10 health checkups (once a year).

Dental Services — Texas Health Steps provides comprehensive dental care, including emergency, preventive, therapeutic, and orthodontic services. Children and young adults are eligible to receive routine dental checkups every six months starting at six months of age. Emergency or medically necessary dental services are available to children and young adults at any time from birth through age 20.

Vision Services — Each Texas Health Steps medical checkup includes:

- a vision screening;
- diagnosis and treatment, including eyeglasses every two years for defects in vision; and
- one eye examination per state fiscal year (September through August).

Lost or destroyed eyeglasses are replaced with no limit on the number of replacements. The person may receive additional services that are medically necessary because of a vision change.

Hearing Services — Texas Health Steps medical checkups also include a hearing screening. Additional testing for hearing problems, as well as diagnosis, treatment, and hearing aids, are available through the Medicaid Program.

Case Management for Children and Pregnant Women — To encourage the use of cost-effective health and health-related care, Case Management for Children and Pregnant Women provides services to children from birth through age 20 who have a serious health condition or who are at risk of developing a serious health condition. Services are also provided to high-risk pregnant women of all ages. Together, the case manager and the family assess the medical, social and educational needs of the eligible recipient.

Texas Health Steps Comprehensive Care Program (CCP) — This program provides expanded benefits to Texas Health Steps persons. Under CCP, people under age 21 are eligible for any medically necessary and appropriate health care service covered by Medicaid. Limitations of the current Texas Medicaid Program do not apply to these people. Expanded benefits include durable medical equipment and supplies, prosthetics, orthotics, private-duty nursing, and therapeutic services.

A-1531.1 Accessibility of Texas Health Steps Services

Revision 19-3; Effective July 1, 2019

Medical Programs (except TP 08, TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, TP 42 and TP 56)

HHSC's Texas Health Steps Outreach and Informing contractors and local Texas Works staff provide initial and periodic outreach and information to help people access Texas Health Steps services. For example, the contractors and local Texas Works staff can help find a Texas

Health Steps provider or provide information about HHSC's Medical Transportation Program (MTP). The Texas Health Steps Outreach and Informing contractor can also help with scheduling a Texas Health Steps appointment.

When a person under 21 is certified for Medicaid, the enrollment broker sends written information to households that include a welcome notification at certification and letters when a child's checkup is due per the Texas Health Steps periodicity schedule.

MTP provides non-ambulance transportation to a doctor or dentist office, hospital, drug store, or any place a person may receive Medicaid services. MTP is available to Medicaid-eligible people and necessary attendants when they have no other means of transportation. Children 14 and under must travel with a parent or guardian, and children 15–17 may travel alone if a parent or guardian fills out the proper consent form. An HHSC contractor or a private contractor of the person's choice, such as a parent, friend, neighbor or volunteer may provide transportation. A private contractor:

- must have a written agreement with the MTP before providing the service; and
- will be reimbursed for mileage to an authorized facility at the state rate.

If it is medically necessary for a person through age 20 to be away from home overnight, MTP approves cost-effective meals, lodging, and up-front funds for the person and the person's attendant.

Households may contact MTP by calling toll-free 877-633-8747.

Complete Form H1093, Texas Health Steps Extra Effort Referral, if a household requests help accessing MTP services.

For more information on MTP and a list of frequently asked questions visit the MTP page.

A-1531.2 Texas Health Steps Service Providers

Revision 19-3; Effective July 1, 2019

Medical Programs (except TP 08, TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, TP 42 and TP 56)

Texas Health Steps is a Medicaid health care program for children from birth through age 20. The Texas Health Steps services are delivered by both public and private providers. Physicians, dentists, advance practice nurses, physician assistants, clinics, hospitals, Federally Qualified Health Centers (FQHCs) and others offer Texas Health Steps services to eligible people. Providers must enroll in Medicaid and enroll as a Texas Health Steps provider.

A-1531.3 Program Administration

Revision 19-3; Effective July 1, 2019

Medical Programs (except TP 08, TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, TP 42 and TP 56)

To comply with the *Frew* lawsuit requirements, staff play a role in educating people about the Texas Health Steps program. Within the Texas Health Steps program, "outreach" and "informing" are terms applied to efforts, strategies, plans, events, organized activities, and courses of action taken to advertise, educate and increase the number of Texas Health Steps checkups.

A-1531.4 Explanation of Benefits

Revision 20-1; Effective January 1, 2020

Medical Programs (except TP 08, TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, TP 42 and TP 56)

To help inform Medicaid recipients, Texas Health Steps Outreach and Informing staff provide the following materials to HHSC:

- A desk reference containing Texas Health Steps program information. The desk reference has toll-free numbers, call center hours and website addresses for Texas Health Steps and the Medicaid Transportation Program. The desk reference contains information that is consistent with the current Texas Health Steps periodicity schedule.
- The Texas Health Steps brochure, "Don't Miss a Beat," presents easy to understand information about the Texas Health Steps program.
- The Appointment Education Brochure, known as "Keep Your Child's Checkups in Check," provides helpful tips to make doctor or dentist visits a positive experience.
- A current Texas Health Steps wallet card, "Checkups Help Children Stay Healthy!" is given to every Medicaid-eligible household with a child through age 20. Families use the cards as a quick reference for when a child is due for a Texas Health Steps dental or medical checkup, based on the child's age. The back of the card provides important information on immunizations.

Each household is given the brochures and a wallet card at:

- initial certification or any time there is a reapplication;

- renewal, if the household has not complied with Texas Health Steps requirements and a face to face interview is required; or
- any time a household requests them.

The materials can be sent by mail if the person is interviewed by phone or when no interview is conducted.

Texas Health Steps materials may be ordered online.

Supervisors must ensure that all staff have the following Texas Health Steps materials and use them as required:

- a desk reference;
- "Don't Miss a Beat" and "Keep Your Child's Checkups in Check " brochures;
- "Checkups Help Children Stay Healthy!" Texas Health Steps wallet cards; and
- Form H1093, Texas Health Steps Extra Effort Referral. This form is used to help people who need:
  - to schedule a Texas Health Steps checkup or appointment;
  - more information on Texas Health Steps medical, dental and case management services; and
  - services other than those listed above.

Fax Form H1093 to Texas Health Steps Outreach and Informing staff at 512-533-3867.

A-1531.5 Compliance Requirements

Revision 26-1; Effective Jan. 1, 2026

TP 44 and TP 48

Starting at 2 years old, children under 18 must comply with the regimen of care prescribed by the Texas Health Steps Program. At the first redetermination, check for overdue screening dates. If one exists, contact the caretaker and allow the caretaker to self-declare that the child:

- had the screening;
- is scheduled for the screening; or
- has not been screened but has good cause.

Send Form H1024, Subject: Self-Declaration Notice, to get the information if unable to contact the caretaker by phone.

Deny the EDG for failure to provide if the household does not return Form H1024. If the household returns Form H1024 indicating noncompliance, schedule the caretaker for a phone interview and emphasize the importance of the checkups. Use the Health Care Orientation Quick Reference Guide and Enrollment Script, when a recipient has an interview due to noncompliance with Texas Health Steps or Health Care Orientation. If the person does not keep the appointment, deny the EDG for Noncompliance with Health Care Orientation.

Note: The denial applies to all Children's Medicaid EDGs for the household, except TP 45.

When a caretaker fails to cooperate with the Texas Health Steps requirement, explore good cause before denying the EDG for noncompliance. The caretaker may claim good cause for the following reasons:

- **Medical** — A screening puts the child's health at risk. The person may provide medical records, a certificate, affidavit or statement from a licensed physician showing that the screening would be damaging to the health of the child. If verification from Texas Health Steps staff shows the child has had a screening within 12 months before the overdue date, allow medical good cause. Texas Health Steps staff will work with the provider to get the child back on schedule.
- **Religion** — The family has a religious belief that does not allow the child to have a screening. The applicant may provide a verbal statement for the child stating that the screening conflicts with the practices of a recognized church or religious organization that the family adheres to.
- **No medical provider or transportation** — There is no medical provider or transportation available within the geographic area. Regional Texas Health Steps staff provide this information to staff on a quarterly basis.

The person must provide verification of good cause. Once good cause for not cooperating with the Texas Health Steps requirements is established, select the good cause reason in Data Collection.

Use the following chart to determine when to start good cause.

If staff determine that good cause exists at	then
a complete review,	start good cause the month the person provides verification.
an incomplete review,	start good cause the month after the person provides verification.
reapplication,	start good cause the month of reapplication.

The good cause end date is the month staff determine the person no longer has good cause or is claiming good cause.

Note: Due to continuous eligibility, an EDG will not deny in the middle of the certification period, even if good cause no longer exists or is being claimed.

At the next redetermination, if the same overdue date shows for the child, the caretaker must provide verification that the child had the checkup, has a phone interview appointment before the redetermination or has good cause for not complying.

Deny the Medicaid EDGs for all the children in the family, except TP 45 coverage, if any certified child's Texas Health Steps screening is overdue and the caretaker does not comply with the requirements, show good cause or have a phone appointment. A caretaker may self-declare on Form H1024 or by phone if there is a good cause reason that the child has not had the checkup.

Related Policy

Scheduling Appointments, A-122.2
Continuous Medicaid Coverage, A-832
General Reminders, A-1510
Processing Children's Medicaid Redeterminations, B-123
Health Care Orientation Quick Reference Guide, C-1118
Good Cause for Texas Health Steps Noncooperation, A-2124.5

A-1532 Medicaid

Revision 25-1; Effective Jan. 1, 2025

Medical Programs

Applicants must be informed that:

- they will receive a Your Texas Benefits Medicaid ID card if certified;
- they must show the Medicaid ID card to medical providers;
- each person can receive three paid prescriptions a month;
- if they lose their Medicaid ID card, they can request a new one by calling 855-827-3748 and providers can still verify Medicaid eligibility without the card; and
- Medicaid will not reimburse them for any bills they pay.

Exception: The following Medicaid recipients are eligible for unlimited paid prescriptions:

- managed care recipients;
- nursing facility residents; and
- people under 21, through the month of their 21st birthday.

Note: Lost or destroyed prescriptions may be replaced by contacting the pharmacy that originally filled the prescriptions. The pharmacy can call the vendor drug toll-free pharmacy provider line to get procedures for overriding the system.

If the household includes members who are elderly or have disabilities who wish to apply for Medicaid, but who do not qualify for any medical programs for families and children, advise them to apply for an HHSC MEPD program by completing the Form H1200, Application for Assistance — Your Texas Benefits. Refer them to the Your Texas Benefits website, 211, or their nearest local office.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 56

Applicants living in a managed care area must be informed that they are required to select a managed care plan and primary care physician.

Emergency Medicaid

Inform applicants certified for Emergency Medicaid that Medicaid coverage is limited to the dates of an emergency medical condition.

Inform pregnant women certified for Emergency Medicaid that they will receive coverage through the 12-month postpartum period.

Inform the household that a child under 19 certified for Emergency Medicaid will receive coverage for a continuous 12-month certification period.

Inform households certified for continuous coverage that only services needed to stabilize the patient's condition during an emergency or life-threatening situation are covered. Services provided after the emergency condition becomes stable are not covered.

TP 40

Encourage the pregnant woman to start receiving prenatal care.

A-1532.1 Spend Down EDGs

Revision 25-1; Effective Jan. 1, 2025

TP 56 and TP 32

For applications with spend down, verbally explain the following:

- Children or pregnant women in the certified group are not eligible for Medicaid until spend down is met, such as when the household's excess income is depleted with medical expenses incurred by members of the budget group. Pregnant women who meet the spend down amount receive continuous eligibility through the end of the 12-month postpartum period. They are not required to meet the spend down amount again.
- The eligibility determination system mails Form H1120, Medical Bills Transmittal, and Form H3087S, Spend Down Medicaid Identification, to the applicant. Form H1120 provides the Medically Needy Clearinghouse with information needed to determine spend down for clients and provides the applicant with information needed to submit medical bills to the Clearinghouse. Form H3087S summarizes the spend-down amount and potential eligible months and explains to providers how they can help the applicant by submitting bills.
- The household or a provider must submit bills to the Medically Needy Clearinghouse. The Clearinghouse must receive the bills within 30 days of the later of the following dates:
  - the day Form TF0001, Notice of Case Action, processes; or
  - the last day of the application month.
- Contact the Clearinghouse if the 30-day time limit is near and there is a delay getting bills from a provider, third-party resources (TPR) information, etc. The Clearinghouse allows bills paid during the month(s) of potential eligibility by:
  - members of the household composition; and
  - state or local government agencies, such as County Indigent Health Care, Children with Special Health Care Needs, Maternal and Infant Health Improvement Act.
- The Clearinghouse also allows unpaid bills that are itemized no matter of when they were incurred. Itemized bills must include:
  - name of the provider;
  - date the service was provided;
  - date(s) and amount(s) paid toward the bill; and
  - balance due.
- If a bill was incurred 60 days or more before the applicant submits it, the applicant must provide a current itemized statement. Assist the applicant in determining whether bills are current, itemized, and complete, if requested. The applicant must submit claims to TPRs, if any, before submitting the bills to the Clearinghouse. When submitting the bills, the applicant must provide the Clearinghouse with verification that a TPR will not pay certain bills or portions of bills. An Explanation of Benefits (EOB) provides this information. The applicant must answer the Clearinghouse's request for additional information no later than 30 days after the:
  - last day of the application month; or
  - date of the Clearinghouse's request.
- Advise the applicant of the types of assistance available to help with the spend-down process.

On the same day staff approve the EDG, they send to the applicant:

- Form TF0001, Notice of Case Action;
- Form H3087S, Spend Down Medicaid Identification;
- Form H1120, Medical Bills Transmittal; and
- a preaddressed Clearinghouse envelope for the applicant to use to submit bills to the Clearinghouse.

Do not give Form H1120 to anyone other than the applicant or the applicant's AR. Explain that it is best to submit all bills at the same time because the Clearinghouse must establish a hierarchy when processing bills to meet spend down. This hierarchy ensures that spend down is met by bills that are not reimbursable before reimbursable bills because bills that are not reimbursable:

- were incurred before a month of potential eligibility; or
- are not for Medicaid-covered services.

A-1533 Transitional and Post Medicaid

Revision 15-4; Effective October 1, 2015

TP 08

The individual should be informed that the household may be eligible for additional months of transitional Medicaid and child care if TP 08 is denied because of earned income (TP 07).

The household should be informed that they may be eligible for four additional months of post Medicaid if TP 08 is denied because of spousal support income.

The individual should also be informed that if the household is not eligible for transitional or post Medicaid, the household may be eligible for other medical program coverage.

A-1534 Requirement to Report Accidents

Revision 15-4; Effective October 1, 2015

Medical Programs

Staff should instruct the individual to report accidents. This is to determine whether the individual has any TPRs other than Medicaid that could cover medical expenses.

A-1540, Redeterminations

Body

Revision 13-2; Effective April 1, 2013

A-1541 Periodic Redeterminations and Special Reviews

Revision 26-2; Effective April 1, 2026

TANF

Staff explains to the person that HHSC will:

- periodically redetermine the household's EDG; and
- send an appointment for the redetermination.

Staff deliver the Texas Works Message to TANF recipients.

Related Policy

Pre-Application Process, A-111

A-1542 Special Reviews

Revision 15-4; Effective October 1, 2015

All Programs

Staff explains to the individual:

- that a special review is set for the individual's EDG,
- the purpose of the special review, and
- how and when HHSC will notify the individual of the special review.

A-1543 Notice of Expiration

Revision 15-4; Effective October 1, 2015

SNAP

TIERS automatically sends an expiration notice to households before their certification ends.

Exceptions: The individual may be given Form H1830, Application/Review/Expiration/Appointment Notice, and Form H1010, Texas Works Application for Assistance — Your Texas Benefits, at certification if the advisor approves an EDG for:

- one or two months, or
- three months and the advisor completes the certification after cutoff in the first benefit month.

A-1550, Issuance and Use of Benefits

Body

Revision 04-1; Effective January 1, 2004

A—1551 Interview Staff Responsibilities

Revision 22-2; Effective April 1, 2022

TANF and SNAP

Staff should inform the person about:

- how HHSC issues TANF and SNAP benefits;
- how the person uses those benefits; and
- the person's responsibilities.

Related Policy

Explanation of Cardholder Responsibilities at Interview, B-239.1

A—1552 EBT Issuance Staff Responsibilities

Revision 22-2; Effective April 1, 2022

TANF and SNAP

EBT issuance staff are responsible for explaining Lone Star Card rules and guidelines to the person when issuing a Lone Star Card.

Related Policy

Issuance Staff Requirements for Client Training, B-239.2

A—1553 Use of TANF Benefits

Revision 15-4; Effective October 1, 2015

TANF

Staff should explain that TANF benefits can only be used to purchase goods and services essential or necessary for the welfare of the family. This includes food, clothing, housing, utilities, furniture, transportation, telephone, laundry, medical supplies not paid by Medicaid, and incidentals such as household equipment, supplies, and recreation for children. Staff must advise recipients that failure to use the benefits as required may result in HHSC establishing a protective payee (as explained in A-222, Who Is Not Included).

A—1554 Use of SNAP Benefits

Revision 20-4; Effective October 1, 2020

SNAP

Staff must explain the following rules regarding use of SNAP benefits:

- SNAP benefits may be used to purchase food items and garden seeds at retailers approved by the U.S. Department of Agriculture (USDA). This includes approved online retailers. They may not be used for hot, ready-to-eat foods or food marketed to be heated in the store (except as listed in B-400, Special Households);
- SNAP benefits may not be used to pay online fees of any type, such as shipping, delivery, service or convenience fees;
- SNAP benefits may not be used to pay off charge accounts;
- Change is not given on EBT food account purchases; and
- Sales tax may not be charged on any item purchased with SNAP benefits.

A—1555 Use of One-Time Temporary Assistance for Needy Families (OTTANF) Benefits

Revision 15-4; Effective October 1, 2015

OTTANF

Staff should ensure that OTTANF applicants understand that OTTANF benefits are intended as emergency cash assistance for families who do not currently receive TANF but who are otherwise eligible. In addition to meeting TANF requirements, the household must meet one of the four crisis criteria explained in A-2440, Determining Crisis Criteria (OTTANF).

HHSC issues a $1,000 payment with the intent that it will:

- resolve a short-term crisis,
- keep the household connected to the workforce, and
- serve as a diversion from ongoing TANF.

Staff shall explain the 12-month ineligibility period and obtain original signatures on Form H1072, One Time Temporary Assistance for Needy Families (OTTANF) Acknowledgement.

A-1560, Documentation Requirements

Body

Revision 19-3; Effective July 1, 2019

All Programs

The following must be documented:

- the nature of expected changes and when the person expects the change to occur;
- the status of overpayments, and an explanation of recoupment action;
- the refusal or failure to sign Form H1350, Opportunity to Register to Vote, in TIERS Case Comments; and
- in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, that staff gave or mailed form VR30, Texas Voter Registration Application, to the person, authorized representative or representative payee, providing the person with an opportunity to register to vote.

Related Policy
Registering to Vote, A-1521

TANF

The following situations must be documented if the person:

- has good cause for not cooperating with Texas Health Steps services;
- does or does not want Texas Health Steps services; and
- chooses to withdraw from the TANF program because of Texas Works activities.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

A-1600, School Attendance

A-1610, Eligibility Requirement

Body

Revision 19-1; Effective January 1, 2019

TANF

The following persons must attend school full time if they do not have a high school diploma or general equivalency diploma (GED):

- An eligible dependent child age 6 to 18 living with a caretaker or a second parent
- A teen parent younger than 19, even if disqualified

A child who is age 6 on or before Sept. 1 of the current school year must attend school.

Example 1: If a child turns age 6 on Aug. 31, school attendance must be verified at the next complete review on or after Sept. 1.

Example 2: If a child turns age 6 on Sept. 2, verification of school attendance is not required at the next complete review on or after Sept. 1, and no penalty should be imposed for not attending school.

If a child or teen parent who is home-schooled is attending school, the parent's statement that the child attends school at home is acceptable.

TANF

A child age 18, in school (high school, technical, or vocational) full time, and expected to graduate before or in the month of the student's 19th birthday is eligible for Temporary Assistance for Needy Families (TANF) through the month of graduation.

A child who will not graduate until after the month of the student's 19th birthday is not eligible after the month of the student's 18th birthday.

Age	In School?	Graduation Month	Eligible?
16 or 17	Yes	N/A	Yes
16 or 17	No	N/A	Yes
18	Yes	Before or in the same month as 19th birthday	Yes, until graduation
18	Yes	After 19th birthday	No, not after month of 18th birthday
18	No	N/A	No
Over 19	N/A	N/A	No

SNAP and Medical Programs except TP 08 and TA 31

School attendance requirements are not applicable for these programs. For the Supplemental Nutrition Assistance Program (SNAP), if a child younger than 18 works and is in school, the child's earned income may be excluded. See A-1323.1, Children's Earned Income.

TP 08 and TA 31

School attendance requirements only apply when the only dependent child(ren) of a parent or caretaker relative applying for TP 08 or TA 31 is(are) age 18 at application and redetermination.

A child(ren) age 18 meets the school attendance requirements through the month of graduation when they:

- attend school in any of the following educational settings:
  - high school;
  - technical school;
  - vocational school;
  - trade school; or
  - home school;
- attend school full time; and
- are reasonably expected to graduate before or in the month of the student's 19th birthday.

The parent or caretaker relative is eligible for TP 08 or TA 31 through the month the child graduates if they meet all other eligibility criteria. A child who will not graduate until after the month of the student's 19th birthday is not considered a dependent child after the month of the student's 18th birthday.

Example 1: If there are two dependent children, one child is age 6 and the other child is age 18, and their parent is applying for TP 08, school attendance requirements do not apply to the child who is age 18 since there is another dependent child, age 6, for the TP 08 parent or caretaker relative to claim.

Example 2: If there are two dependent children both age 18 and their parent is applying for TP 08, school attendance requirements apply to both children because both children are age 18 and there are no other dependent children for the TP 08 parent or caretaker relative to claim.

A-1620, Determining Attendance

Body

Revision 15-4; Effective October 1, 2015

TANF

After the caretaker and second parent or teen parent sign Form H1073, Personal Responsibility Agreement, staff must verify whether the child or teen parent met the school attendance requirement.

School attendance must be verified:

- at each complete review;
- when curing a school attendance penalty; and
- at application, if school is in session.

Notes:

- School is considered to be in session during holiday breaks.
- If an individual applies when school is not in session and indicates a child is not meeting school attendance requirements and will not meet the requirement when school begins, a full-family sanction is imposed. See A-2131.1, Initial Application.

At complete or incomplete review, if the child is determined to have 10 or fewer excused or unexcused absences per semester, no further action is required. If the child has more than 10 absences, Form H1086, School Attendance Verification, is used to request verification of school attendance. The school determines whether the child meets school attendance requirements, regardless of the number of absences.

At application, if verification is required, the application is pended for 10 days to allow the household time to cooperate. If the household has proof of the child's attendance or excused absences for a minimum of five consecutive school days during the 10-day pending period, the child is considered to be cooperating and no penalty is imposed.

Note: Accept verification for a different 10-day period if received prior to certification.

During the summer months, the advisor must verify whether a child or teen parent met the school attendance requirement since the last complete review. If the child or teen parent:

- met the school attendance requirement, no further action is required. The child or teen parent meets school attendance requirements by:
  - being promoted,
  - attending summer school, or
  - graduating.
- did not meet the school attendance requirement, a full-family sanction is imposed.

TANF, SNAP, TP 08 and TA 31

The local school system determines the criteria for half- or full-time attendance. A child meets the criteria even if he is out of school because of vacation, temporary illness, or family emergency.

Children with disabilities may attend fewer hours than other students. They may also receive instructions from a visiting teacher at home and still meet the school attendance requirements.

A child enrolled in a vocational adjustment program is in school full time.

A—1621 Exemptions from School Attendance Requirements

Revision 17-1; Effective January 1, 2017

TANF

A child is exempt from the school attendance requirements if the child:

- is eligible to participate in a school district's special education program;
- is at least age 16 and attends a course to prepare for the high school equivalency exam;
- is enrolled in the Texas Academy of Mathematics and Science;
- is enrolled in the Texas Academy of Leadership in the Humanities;
- is specifically exempted under another law;

- has a physical or mental condition of a temporary and remediable nature that makes it unfeasible for the child to attend school. Staff must obtain a statement from the child's physician specifying the:
  - child's medical condition; and
  - anticipated period of the child's absences from school.

A-1630, Failure to Cooperate with School Attendance

Body

Revision 21-1; Effective January 1, 2021

TANF

If a child or teen parent does not meet school attendance requirements, impose a school attendance penalty and apply a full-family sanction.

If the person does not cooperate with school attendance requirements at ...	then ...
application (before certification but after signing the Personal Responsibility Agreement),	refer to A-2144, Imposing a Penalty.
complete review or incomplete review,	refer to A-2144.
reapplication,	• if the person has an open penalty, follow the procedures in A-2151, Open Penalty at Reapplication in Pay for Performance. • if the person does not have an open penalty, follow the procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reapplication.

TP 08 and TA 31

Deny TP 08 or TA 31 if the only dependent child(ren) who makes the person eligible for TP 08 or TA 31 is age 18 and:

- has graduated;
- is expected to graduate after the month of their 19 birthday. **Note**: A child who will not graduate until after the month of their 19th birthday is not considered a dependent child after the month of their 18th birthday;
- is not attending high school, technical school, vocational school, home school, or trade school full time; or
- school attendance is not verified by the due date.

Related Policy

Form TF0001 Required (Adequate Notice), A-2344.1

A—1631 Good Cause for Noncooperating with School Attendance

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

Good cause for not cooperating with the school attendance requirement must be explored at:

- application,
- each complete review, and
- the individual's request.

Good cause exists if:

- the teen parent has a child under age 12 weeks; or
- no one in the home is willing and able to care for the child, and free child care is not available through the Texas Workforce Commission (TWC) or the school district. The local workforce board should provide free child care paid by TWC.

The individual's statement about a household member's inability to provide care is acceptable. Good cause is allowed only if TWC and the local school district provide verification that they will not provide free child care.

A—1632 Curing the School Attendance Penalty

Revision 15-4; Effective October 1, 2015

TANF

After a penalty is imposed, the child or teen parent can cure the penalty:

- by attending school with no unexcused absences for the next 30 days;
- by claiming good cause; or
- during the summer months by:
  - being promoted,
  - attending summer school, or
  - graduating.

The individual is responsible for reporting when the child or teen parent has cured the penalty or has good cause.

Note: See A-2151, Open Penalty at Reapplication in Pay for Performance, when curing an open school attendance noncooperation for a reapplication under pay for performance.

A-1640, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

TANF

School attendance must be verified:

- at each complete review. During the summer months, the advisor must determine whether the child or teen parent met the requirement since the last complete review;
- when curing a school attendance penalty; and
- at application, if school is in session. **Notes:**
  - School is considered to be in session during holiday breaks.
  - If an individual applies when school is not in session and indicates a child is not meeting school attendance requirements and will not meet the requirement when school begins, a full-family sanction is imposed. See A-2140, Full-Family Sanction.

TP 08 and TA 31

Advisors must verify full-time school attendance when the only dependent child(ren) of an individual requesting TP 08 or TA 31 is(are) age 18 at application and redetermination. When an individual on TP 08 has dependent children younger than age 18, no verification of school attendance is required for the younger children or for the 18-year-old.

During the summer months, staff must determine whether the dependent child met the school attendance requirements at the end of the previous school year and confirm that the child intends to meet the requirements when school begins.

A–1641 Verification Sources

Revision 22-3; Effective July 1, 2022

TANF, SNAP, TP 08 and TA 31

School attendance may be verified with the following sources:

- school attendance registrar records;
- current report card;
- Form H1086, School Attendance Verification (PDF); or
- statement from the person indicating the child is home schooled, if not questionable. **Note:** If the person's statement is questionable, request copies of their curriculum, study materials or other proof of coursework.

Related Policy

Children's Earned Income, A-1323.1
Questionable Information, C-920
Providing Verification, C-930

A-1650, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

The following information must be documented:

- verification source;
- date verified;
- exemptions, if any; and
- reason for good cause.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

A-1700, Management

A-1710, General Policy

Body

Revision 22-4; Effective Oct. 1, 2022

SNAP and TANF

Explore management at each application, redetermination and when a change affects how the household meets its expenses.
A thorough discussion of how a household meets its expenses can help staff evaluate the accuracy of information the household provides.
Ask two questions to examine management:

- How long has the household managed this way?
- Are the household's reported net income and resources enough to pay their expenses?

Require additional explanation and verification when management is questionable or negative.

Related Policy

Advisor Action, A-1730

A-1720, How to Evaluate Management

Body

Revision 22-4; Effective Oct. 1, 2022

SNAP and TANF

Explore past, present, and future management. Before the interview, review the previous Form H1010, Texas Works Application for Assistance — Your Texas Benefits, Form H1010-R, Your Texas Works Benefits: Renewal Form and case comments. Decide if the information given in the past is consistent with the current situation.

Review the EDG and determine if the household's reported net income meets its basic expenses. Examples of basic expenses include, but are not limited to:

- food;
- transportation;
- shelter;
- utilities; and
- recurring expenses such as:
  - credit card payments;
  - loans;
  - insurance;
  - clothing; and
  - disposable diapers.

Review Data Broker reports and other on-line verification sources to identify any unreported household income, resources and expenses.
Example: Credit reports may show regular payments that cause monthly expenses to exceed reported income.

If net income and resources do not cover paid expenses, ask the household if anyone has or receives income from:

- tips;
- commissions;
- overtime;
- bonuses; or
- part-time employment such as:
  - paper routes;
  - food delivery;
  - ride-sharing;
  - street vending;
  - babysitting;
  - sewing;
  - laundry;
  - lawn and garden work;
  - carpentry; and
  - seasonal labor.

Explore whether the household pays expenses by:

- borrowing from friends or relatives;
- receiving cash contributions or gifts;
- using checking or savings accounts; or
- receiving assistance from another source that pays expenses directly to the vendor, such as:
  - Housing and Urban Development (HUD) rental assistance;
  - the Salvation Army;
  - community-based organizations;
  - insurance; or
  - friends or relatives.

If the applicant intends to repay a loan, explore how the applicant will pay it back.

If the household reports temporary loans, gifts or vendor payments, set a special review to check management based on the estimated temporary payment end date.

Exception: Do not set a special review for management for streamlined reporting households.

Related Policy

Data Broker Combined Report Sources With Credit Report, C-827

A-1730, Staff Action

Body

Revision 22-4; Effective Oct. 1, 2022

SNAP and TANF

Step	If ...	then...
1.	management is questionable at initial application, Temporary Assistance for Needy Families (TANF) complete review or Supplemental Nutrition Assistance Program (SNAP) redetermination,	• verify whether the household's basic billed expenses are paid or delinquent; and

Step	If ...	then...
		• go to Step 2.
	a recent change causes questionable management,	• TANF – Set a special review. • SNAP (SR) – Take no action. • NPA-SNAP (Non-SR) – Follow policy to shorten the certification period.
2.	verification shows basic billed expenses are paid,	• go to Step 3.
	verification shows basic billed expenses are past due,	• follow policy to monitor questionable management.
	the household does not return verification,	• deny the household.
3.	management is negative for three months or more,	• verify how the household paid for expenses (vendor payments, in-kind, cash contributions or unreported income).
	management is negative and the household provides proof that the household paid billed expenses with non-recurring assistance,	• follow policy to monitor questionable management.
	management is negative and the household fails to provide available verification of the income or resources used to meet their expenses,	• TANF – Deny the household at application or complete or incomplete review. • SNAP – Deny the household only at application or redetermination.
	management is negative for less than three months,	• follow policy to monitor questionable management.

Related Policy

How to Evaluate Management, A-1720
Monitoring Questionable Management, A-1731
Length of Certification, A-2324
Streamlined Reporting Households, A-2350
Processing Special Reviews, B-125
What to Report, B-621
Shortening Certification Periods as a Result of a Change, B-635

A–1731 Monitoring Questionable Management

Revision 22-4; Effective Oct. 1, 2022

TANF

Set special reviews to monitor cases with questionable management.

SNAP

Set a special review due to questionable management for non-streamlined reporting (SR) households. Do not set a special review due to questionable management for SR households.

Related Policy

Length of Certification, A-2324

A-1740, Verification Requirements

Body

Revision 22-4; Effective Oct. 1, 2022

SNAP and TANF

Verify if the household's basic expenses are paid or delinquent when the household's billed expenses exceed reported net income or resources at application, redetermination, change and at special reviews set for management. **Exception**: Do not set special reviews due to questionable management for streamlined reporting households.

A-1750, Documentation Requirements

Body

Revision 22-4; Effective Oct. 1, 2022

SNAP and TANF

When past, present or future management is negative or questionable, document the person's explanation of how the household manages its expenses.

When the reported net income is enough to cover all reported expenses, completing the Management - Details logical unit of work (LUW) in the Texas Integrated Eligibility Redesign System (TIERS) Data Collection meets the documentation requirements. This includes expenses listed in the Data Broker credit report, such as credit card expenses.

Document the steps taken to resolve or clear management that has been negative for more than three months.

Related Policy

Staff Action, A-1730
The Texas Works Documentation Guide

A-1800, Employment Services

A-1810, General Policy

Body

Revision 12-3; Effective July 1, 2012

TANF and SNAP

The Employment Services Program (ESP) consists of two programs. They are Choices for Temporary Assistance for Needy Families (TANF) individuals and Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T) for SNAP individuals. Recipients must participate in these programs unless exempt. If a nonexempt member does not comply, he may be subject to a penalty that results in a full-family sanction for TANF and either a denial or disqualification for SNAP.

TANF

The Texas Workforce Commission (TWC) and Local Workforce Development Boards (LWDBs) determine the level of Choices services to provide in each county according to available Choices resources. After coordination with state office, TWC and the LWDB designate a county to provide one of two service levels:

- full service; or
- minimum service.

Full Service Requirements

Each nonexempt TANF caretaker or second parent who lives in a full service Choices county must participate in Choices employment services if contacted. Nonexempt and exempt members in full service Choices counties may voluntarily participate in employment services at any time. Exempt individuals are eligible for the same services as nonexempt individuals.

Minimum Service Requirements

Individuals in minimum service Choices counties are exempt from participation requirements because of the lack of available Choices resources in the area (even when they are coded mandatory registrants). Individuals in minimum service counties may choose whether or not to participate in Choices services offered to them.

SNAP

Each nonexempt household member age 16 through 59 must be registered for employment services at initial certification.

Exception:

For expedited service, register the applicant being interviewed unless he is:

- exempt from registration; or
- a nonparticipating authorized representative.

A—1811 Strikers and Employment and Training (E&T)

Revision 01-1; Effective January 1, 2001

SNAP

A striker must comply fully with the work registration requirement. He does not have to accept employment at a location subject to a strike or lock-out. If a strike is prohibited under either the Taft-Hartley or Railway Labor Acts, Health and Human Services Commission (HHSC) considers this a continuing offer of suitable employment to the striker. Failure by the striker to return to this employment, for any reason, is failure to comply with work registration requirements. This makes the entire household ineligible.

A-1820, Employment Services Programs Procedures

Body

Revision 12-3; Effective July 1, 2012

A-1821 Choices

Revision 12-3; Effective July 1, 2012

TANF

In all counties:

- determine the work registration status of all individuals; and
- obtain information about education level, work history, and vocational training for caretakers and second parents.

Note: See State Time Limits, A-2500, for state time limit tier levels for TANF individuals certified as caretakers and second parents.

A-1821.1 Choices Exemptions

Revision 13-4; Effective October 1, 2013

TANF

A member is exempt from participation if he is one of the following:

Code A (Child under 19 years of age) — A child, age 18 or younger.

Code C (Caring for an ill or disabled child in the home) — Needed at home to care for an ill or disabled child in the household, even if that person is not a member of the certified group. The caretaker must provide a completed Form H1836-B, Medical Release/Physician's Statement, to claim this exemption. This includes caring for a family member receiving disability benefits such as Supplemental Security

Income (SSI). See A-1821.1.2, Claiming Exemption Due to Caring for a Disabled Household Member, for specific information of Form H1836-B expectations.

Note: This exemption can be applied to more than one parent/caretaker if there are two or more disabled individuals in the household and it requires more than one person to provide care for the disabled members.

Code E (Disability expected to last greater than 180 days) — Unable to work due to a mental or physical disability expected to last more than 180 days. To claim an exemption based on disability, the individual must provide a completed Form H1836-A, Medical Release/Physician's Statement. Receipt of Social Security benefits based on disability or Veterans Affairs (VA) disability benefits is not an automatic disability exemption for Choices. See A-1821.1.1, Claiming Exemption Due to Disability of Self, for specific information of Form H1836-A expectations.

Code F (60 years of age or older) — Age 60 or older. Obtain verification of age if not already established.

Code G (Meets Caretaker Exemption criteria, child in EDG) and Code R (Meets Caretaker Exemption criteria, child not in EDG) — A single parent or single caretaker relative caring for a child under age one at initial application. See A-1821.5, Caretaker Exemption, for information on setting the caretaker exemption end date.

Notes:

- Neither parent in a two-parent household may receive a caretaker exemption. This includes households with a disqualified legal parent or non-certified parent (for example, legal parent receiving SSI).
- Another relative caretaker whose spouse is in the household may not receive the caretaker exemption.

Code H (Cares for a disabled adult in the home, expected to last greater than 180 days) — Needed at home to care for a disabled adult in the household even if that person is not a member of the certified group and the disability is expected to last more than 180 days. The caretaker must provide a completed Form H1836-B to claim this exemption. This includes caring for a member receiving disability benefits such as SSI. See A-1821.1.2, Claiming Exemption Due to Caring for a Disabled Household Member, for specific information of Form H1836-B expectations.

Note: This exemption can be applied to more than one parent/caretaker if there are two or more disabled individuals in the household and it requires more than one person to provide care for the disabled members.

Code J (Not certified for TANF) — Not certified for TANF for reasons other than being a non-recipient parent (Codes X, V or Y) or sanctioned for Choices (Code W).

Code N (Time Limited Employment Hardship) — Eligible for a state time limit hardship exemption based on lack of available employment opportunities. See A-2543.3, Employment Hardship Exemption (ESP Code N), for detailed information about this work registration code.

Code Q (Time Limited Personal Hardship) — Eligible for a state time limit hardship exemption based on personal disability or caring for a disabled household member. See A-2543.2, Severe Personal Hardship Exemption (ESP Code Q), for detailed information about this work registration code.

Code T (Pregnant and unable to work) — Pregnant and unable to work. To claim an exemption based on pregnancy, the individual must provide proof of pregnancy on Form H3037, Report of Pregnancy, or another document containing the same information and completed by a physician, nurse, advanced nurse practitioner or other medical professional, and a completed Form H1836-A, verifying the disability is due to pregnancy. See A-1821.1.1, Claiming Exemption Due to Disability of Self, for specific information of Form H1836-A expectations.

Code U (Single grandparent 50 or older caring for child under 3) — A single grandparent, age 50 or over, caring for a child under age three. Obtain verification of age and TANF relationship, if not already established.

Code V (SSI Recipient) — An SSI parent.

Code X (Exhausted STL) — A parent who has exhausted his/her state time limits.

Code Y (Disqualified for TPR non-compliance, Disqualified for SSN non-compliance, Has an IPV, Disqualified for failure to report temporary absence of a certified child, Is a fugitive, Has a felony drug conviction, Disqualified for QC non-compliance, Minor parent domicile non-compliance) — A parent disqualified because of:

- third-party resource requirements;
- Social Security number requirements;
- intentional program violation;
- failure to report a child's absence;
- being a fugitive;
- having a felony drug conviction;
- failure to cooperate with Quality Control; or
- noncompliance with the unmarried minor parent domicile requirement.

A-1821.1.1 Claiming Exemption Due to Disability of Self

Revision 09-1; Effective January 1, 2009

Form H1836-A, Medical Release/Physician's Statement, must be obtained to verify a personal disability due to illness, injury or pregnancy. In order for an individual to receive an exemption from Choices requirements due to illness or injury, the disability must be expected to last more than 180 days. A pregnancy-related disability does not have to last any specific length of time.

Note: Receipt of Social Security benefits based on disability or Veterans Affairs (VA) disability benefits is not an automatic disability exemption for Choices.

A new Form H1836-A must be obtained when the form in the file is more than six months old.

If the Form H1836-A on file at the time of review is less than six months old but will reach the six month period during a new certification period, advisors must:

- request a new Form H1836-A at the time of the review; or
- set a special review six months from the date Form H1836-A is signed to request a new Form H1836-A.

Example: The individual has a current Form H1836-A dated in July on file. The advisor interviews the individual for a periodic review in October. Form H1836-A is current at the time of the interview. The advisor may request a new Form H1836-A at the interview or set a special review for December to request a new Form H1836-A.

The following Choices exemption codes require a completed Form H1836-A:

- T – pregnant and unable to work, and
- E – unable to work due to a mental or personal disability and the disability is expected to last more than 180 days.

The medical provider completes Section II, Part A, by checking one box.

If the medical provider checks ...	then the individual is ...
1(a) or 1(b)	mandatory for Choices.
2(a) or 2(b)	mandatory for Choices. **Note:** The medical provider should complete Part B and Part C.
3(a) or 3(b)	exempt from Choices because the disability is permanent or expected to last more than 180 days. **Note:** The medical provider should complete Part C.
3(c) and the individual has a personal or mental disability	mandatory for Choices. **Note:** The medical provider should complete Part C.
3(c) and the individual is disabled due to pregnancy	exempt from Choices because there is no timeframe associated with a disability due to pregnancy. **Note:** The medical provider should complete Part C.

Note: If the medical provider fails to complete Part B or Part C for a Temporary Assistance for Needy Families individual but indicates that the individual is permanently disabled or temporarily disabled for more than 180 days, the individual meets the criteria for a Choices exemption.

A-1821.1.2 Claiming Exemption Due to Caring for a Disabled Household Member

Revision 09-1; Effective January 1, 2009

Obtain verification that the caregiver is unable to work or participate in workforce activities due to illness or injury of an adult or child family member. In order for an individual to receive an exemption from Choices requirements due to a disabled adult family member, the disability must be expected to last more than six months (180 days). There is no timeframe associated with the length of the disability if the individual is caring for a disabled child.

Note: A caregiver caring for an adult or child family member who is receiving disability benefits such as Supplemental Security Income (SSI) does not qualify for an exemption unless the caregiver provides Form H1836-B, Medical Release/Physician's Statement, verifying the caregiver is needed in the home to provide care.

The following Choices exemption codes require a completed Form H1836-B:

- "C" – needed at home to care for an ill or disabled child in the household even if the person is not a member of the certified group, and
- "H" – needed at home to care for a disabled adult in the household even if the person is not a member of the certified group and the disability is expected to last more than 180 days.

A new Form H1836-B must be obtained when the form in the file is more than six months old.

If the Form H1836-B on file at the time of review is less than six months old but will reach the six month period during the new certification period, advisors must:

- request a new Form H1836-B at the time of the review; or
- set a special review six months from the date Form H1836-B is signed to request a new Form H1836-B.

Example: The individual has a current Form H1836-B dated in July on file. The advisor interviews the individual for a periodic review in October. Form H1836-B is current at the time of the interview. The advisor may request a new Form H1836-B at the interview or set a special review for December to request a new Form H1836-B.

The medical provider completes Section II, Part A, by checking one box.

If the medical provider checks ...	then the individual is ...
1 or 2(a or b)	mandatory for Choices.
3(a or b)	exempt from Choices. **Note:** The medical provider must complete Part B.
3(c) and the individual is needed at home to care for an adult family member	mandatory for Choices. **Note:** The medical provider must complete Part B.
3(c) and the individual is needed at home to care for a child	exempt from Choices. **Note:** The medical provider must complete Part B.

A-1821.2 Choices Participation

Revision 13-4; Effective October 1, 2013

TANF

A member is required to participate if he is one of the following:

Code B (Caretaker/Parent under age 19 in school full time) — A caretaker or second parent, age 18 or younger, attending elementary, secondary, vocational or technical school full time.

Code K (Appeal pending with Choices) — Appealing a Choices sanction. Use this code to indicate the individual is appealing the Choices sanction. See Appeals, A-1870, for more information.

Code L (Time limited Severe Economic Hardship, Lives in Economically Deprived County) — Eligible for a state time limit hardship exemption based on residing in a designated hardship county. See A-2543.1, County Hardship Exemption (ESP L), for detailed information about this work registration code.

Code M (Mandatory registrant) — Does not qualify for any of the exemptions and does not meet the Code P criteria. **Note:** Use this code for an individual who receives in-kind income for working.

Code P (Meets TANF full time employment requirement) — Employed or self-employed at least 30 hours per week, and receiving earnings of at least $700 per month. The required compliance is limited to only reporting hours of work. These individuals may be sanctioned if they do not report their hours to Choices staff.

Code W (Sanctioned for Choices nonparticipation) — Sanctioned for TANF based on non-compliance with Choices.

Local Workforce Development Boards (LWDBs) develop a Family Employment Plan with the involvement of all adults on the TANF EDG. In TANF-SP households, both adults must agree who will satisfy their work requirement. All adults on the TANF EDG are required to sign the plan.

Failure to sign the plan or meet the work requirements without good cause results in the LWDB sending a sanction request for the non-cooperating individual. For TANF-SP households, the LWDB will send the following penalty:

If the household's caretaker/parent and second parent are ...	then the LWDB sends a sanction request for ...
both mandatory participants,	the caretaker and second parent. **Note:** If one parent non-complies with Choices and the other parent already has an open Choices penalty (work registration code W or K), the LWDB does not send a penalty request for the parent with the open Choices penalty.
one is a mandatory participant and one is exempt but volunteers,	only the mandatory participant.
one is a mandatory participant and one is exempt but does not volunteer,	only the mandatory participant.

A-1821.3 Work Registration Code Hierarchy

Revision 12-3; Effective July 1, 2012

TANF

TIERS determines the appropriate work registration code based on data collection entries. Staff should review work registration status prior to disposition to ensure the correct work registration code is assigned to an individual. Use the following chart to determine the work registration code that should be assigned if the individual qualifies for more than one work registration code.

Code	Description
V	non-recipient parents who receive Supplemental Security Income
X	non-recipient parents who have exhausted their state time limits
Y	non-recipient parents who have certain disqualifications
J	ineligible for TANF and for Choices
A or F	child under age 19 or adult over age 60
L, N or Q	receiving hardship exemption from the state time limit
G or R	caring for a child under age 1
C	caring for a disabled child
U	grandparent caring for a child under age 3
H	caring for a disabled adult
E	personal disability
T	pregnant and unable to work
K	appeal pending with Choices
W	sanctioned for Choices nonparticipation
P	employed at least 30 hours per week and earning at least $700 per month
B	parent under age 19 and in school full time
M	mandatory participant

A-1821.4 Switching the Exemption — TANF-SP

Revision 02-8; Effective October 1, 2002

TANF

TANF-SP parents may switch participation designations (that is, exempt and nonexempt codes) once if the switch is before or during Choices assessment for the parent initially designated as nonexempt. The exemption code must be one that applies to either parent. Choices staff use Form H2583, Choices Information Transmittal, to inform Texas Works staff when TANF-SP parents request to switch Choices codes. The parent cannot switch after completion of the Choices assessment.

A-1821.5 Caretaker Exemption

Revision 12-3; Effective July 1, 2012

TANF

TANF single parents or single relative caretakers caring for a child under age one at initial application are exempt from Choices participation (Choices exemption Code G or R) until the child reaches age 1. **Note:** Caretakers under age 20 who have not completed high school or its equivalent do not qualify for these Choices exemptions, even if the caretaker exemption end date is in the future. These individuals may be exempt for another reason.

A-1821.5.1 Setting the Caretaker Exemption End Date

Revision 12-3; Effective July 1, 2012

TANF

TIERS sets a caretaker exemption end date based on the youngest child under age 1 in the home at the time of initial certification. See Individual- Summary, Time Limits screen in TIERS for the caretaker exemption end date.

A caretaker is not eligible for this exemption after the end date. The end date does not change when another child is born to the caretaker or moves into the home after TIERS sets the end date.

A-1821.5.2 Resetting the End Date

Revision 17-3; Effective July 1, 2017

TANF

If the child for which the caretaker's exemption end date is based on leaves the home, TIERS resets the end date based on the:

- next older child; or
- date the child leaves the home if no children under one remain in the household.

Contact the IEE/TIERS Technical Help Desk to address any issues with the caretaker exemption end date.

A-1822 E&T Procedures

Revision 24-3; Effective July 1, 2024

SNAP

- In all counties;
- at initial certification;
- each recertification; and
- at a change when a household member becomes subject to the work requirements, such as when adding a new person or someone turns 18:
  - determine each person's registration or participation exemption status;
  - determine a primary wage earner (PWE);
  - ensure the TF0001, Notice of Case Action, includes the SNAP Work Rules information when appropriate. The SNAP Work Rules information tells each member who is subject to the work rules about the requirements that pertain to the designated person; and
  - use the SNAP Work Rules — Verbal Informing Script to inform the person interviewed about each E&T registrant's and ABAWD's rights and responsibilities. The English and Spanish SNAP Work Rules — Verbal Informing Scripts are available for staff use on the Loop.

Notes:

- For mixed households, members exempt from SNAP work rules are not addressed by the work rules information. If the SNAP household contains members who are all exempt from SNAP work rules and there are no ABAWDs, the SNAP work rules information is not included with the TF0001.
- Remind streamlined reporting households of their responsibility to respond to all notices and letters from the employment program.

Related Policy

Determining Primary Wage Earner (PWE) for Noncooperation Situations, A-1844.1

A-1822.1 SNAP Work Requirement Exemptions

Revision 22-1; Effective January 1, 2022

SNAP

Exempt a person from SNAP work requirements if they meet one of the following criteria:

Code A (Child under 16, 16 or 17 and not head of household, or 16 or 17 and attends school or training at least half time) — Age:

- 15 or younger;
- 16 or 17 and not the head of household; or
- 16 or 17 and attending school, including home schooling or an employment training program, on at least a half-time basis.

Code E (Physically or mentally unfit for employment) — Physically or mentally unfit for employment. Require proof of a disability that is not obvious before exempting the applicant. Obtain Form H1836-A, Medical Release/Physician's Statement. A physician's statement with the required information is also acceptable to claim an exemption due to disability of self.

Receipt of a temporary or permanent disability benefit from a private or government source, including VA non-service-connected disability benefits, is acceptable verification that a person is physically or mentally unfit for employment. For VA service-connected disability benefits that are less than 100%, do not exempt the person.

A person who applies for SSI and SNAP at a Social Security Administration (SSA) office receives a work registration exemption until the SSA determines the person's eligibility for SSI.

Code F (60 or older) — 60 or older.

Code G (Caring for a child under 6) — Each parent or other household member responsible for the care of a child under 6.

Note: This exemption can be applied to more than one household member who is responsible for the care of a child under 6 if there are two or more children under age 6 in the household. The number of people who receive the exemption may not exceed the number of children under age 6 in the SNAP household.

Code H (Cares for a person with a disability who is living in the home) — A parent or other household member caring for a person of any age who has a disability and lives with the household. The person who has a disability does not have to be part of the SNAP budget group but must reside at the same address. Require proof that the parent or household member is needed in the home to care for the person with a disability, including a member receiving disability benefits, such as SSI. The household must provide Form H1836-B, Medical Release/Physician's Statement, or a physician's statement with the required information to claim an exemption due to caring for a household member with a disability.

Note: This exemption can be applied to more than one parent or caretaker if there are two or more people with a disability living in the household and it requires more than one person to provide care for the members who have a disability.

Code J (In drug and alcohol treatment program) — A regular participant or outpatient in a drug addiction or alcoholic treatment and rehabilitation program.

Code N (Receiving or applying for unemployment benefits) — Receiving unemployment insurance benefits or has applied but not been notified of eligibility.

Code P (Meets SNAP full-time employment requirement) — Employed or self-employed:

- at least 30 hours a week; or
- receiving earnings equal to 30 hours a week multiplied by the federal minimum wage. If the applicant's income is not enough to meet this exemption, the person must verify that they work at least 30 hours a week.

Allow this exemption for a person:

- who works at least 30 hours a week in exchange for goods or services (in-kind work);
- who works without pay (volunteer labor) at least 30 hours a week with a business, government entity or non-profit organization; or
- who home-schools a child living in the home. The person must home-school the child at least 30 hours a week and be state-certified to conduct home-schooling.

Any combination of the activities listed as an exemption for meeting the full-time employment requirement, or those activities in combination with employment hours, can be used if the combination totals at least 30 hours a week.

Notes:

- The person may choose to average hours or income over the certification period or 12 months to meet this exemption.
- Migrant and seasonal farm workers are exempt if they are under contract or similar agreement with an employer or crew chief to begin work within 30 days.

Code Q (Registered with Choices) — Lives in a full-service Choices county and is nonexempt from Choices participation, or lives in any county and has an open Choices case.

Code S (Student 18 or older in school or a training program at least half time)

- a student 18 or older who is enrolled at least half time in school or a training program, including an institution of higher education, or a person participating in a training program; or
- a refugee who is enrolled at least half time in English as a Second Language (ESL) courses or E&T programs administered by a refugee contractor or Match Grant program.

Related Policy

Claiming Exemption Due to Disability of Self, A-1822.1.1
Claiming Exemption Due to Caring for a Household Member with a Disability, A-1822.1.2
Students in Higher Education, B-410
Work Registration, B-476.1.2

A-1822.1.1 Claiming Exemption Due to Disability of Self

Revision 06-4; Effective October 1, 2006

Form H1836-A, Medical Release/Physician's Statement, must be obtained to verify a disability for individuals who appear capable of employment but claim a disability. There is no requirement that the disability last more than 180 days.

A new Form H1836-A must be obtained when the form in the file is more than 12 months old.

The following E&T exemption code requires a completed Form H1836-A:

- E – physically or mentally unfit for employment if the disability is not obvious.

The medical provider completes Section II, Part A, by checking one box.

If the medical provider checks ...	then the individual is ...
1(a or b) or 2(a or b)	mandatory for E&T.
3(a, b or c)	exempt from E&T.

A-1822.1.2 Claiming Exemption Due to Caring for a Household Member With a Disability

Revision 14-3; Effective July 1, 2014

Obtain Form H1836-B, Medical Release/Physician's Statement, to verify an individual who claims to be needed in the home to care for a household member with a disability. There is no requirement that the disability last more than 180 days.

Obtain a new Form H1836-B when the form in the file is more than 12 months old.

The following E&T exemption code requires a completed Form H1836-B:

- H – a parent or other household member caring for a person of any age who has a disability and lives with the household.

The medical provider completes Section II, Part A, by checking one box.

If the medical provider checks ...	then the individual is ...
1 or 2(a or b),	mandatory for E&T.
3(a, b or c),	exempt from E&T.

A-1822.2 Exempt Members Volunteering to Participate in E&T

Revision 26-1; Effective Jan. 1, 2026

SNAP

Voluntary E&T participants are SNAP applicants and recipients exempt from registering for the E&T Program. They may volunteer to participate in the program but are not sanctioned for noncompliance with E&T requirements.

Screen all household members at certification and recertification. Do this to determine their appropriate work registration status using the exemption criteria in the related policy. Inform households with E&T exempt members who have become adults to participate. They may voluntarily participate in the E&T Program.

Inform the person interviewed about the following employment services that may be available through their local Workforce Solutions Office:

- case-managed job search;
- job readiness, job search help, and job referral and placement help;
- vocational training;
- nonvocational education;
- work experience;
- employment and training services for adults, dislocated workers and youth;
- support services that can help with transportation, childcare, personal safety equipment or other costs for the E&T Program, such as tools, books or uniforms; and
- other education and training opportunities that may be available in the person’s area.

Inform the person that those who volunteer cannot be disqualified for non-compliance with the E&T Program and provide the following TWC information. Visit twc.texas.gov and click on Find Locations or call 800-628-5115.

Document in case comments that all exempt SNAP household members were:

- informed about the E&T Program;
- can participate as a volunteer; and

- were provided with the TWC contact information.

Related Policy

SNAP Work Requirement Exemptions, A-1822.1

A-1823 Work Registration Status Changes

Revision 12-3; Effective July 1, 2012

A-1823.1 Reporting Changes in Work Registration Status

Revision 12-3; Effective July 1, 2012

TANF

Individuals must report changes that could affect employment services within 10 days of the change.

A-1823.1.1 Advisor Action on Status Changes

Revision 13-1; Effective January 1, 2013

TANF

Change the work registration code if:

- the individual reports a change in his exemption status, or
- information in the case record indicates a change in the individual's exemption status.

When the individual has a Code G or R and the youngest child reaches age one, TIERS:

- changes the individual's work registration status based on the hierarchy listed in A-1821.3 at cutoff of the caretaker exemption end date month,
- sends the individual a notice of the change in work registration status, and
- transmits the information to TWC.

Notify the individual on TF0001, Notice of Case Action, that their work registration status has changed.

SNAP

Change the work registration code within 10 days if the individual

- becomes exempt from E&T because he meets the criteria for exemption Code Q.
- loses E&T exemption status because of a
  - change the household is required to report,
  - change in TANF work registration code or open Choices case status, or
  - TANF penalty for Choices noncompliance.

If the individual loses E&T exemption status for any other reason, register the individual at the next recertification.

Notify the individual on TF0001 that their work registration status has changed.

A-1824 Information Transmittal from Choices or E&T Staff

Revision 12-3; Effective July 1, 2012

TANF and SNAP

When Choices or E&T staff discover information during an individual contact, they use Form H2583, Choices Information Transmittal, or Form H1817, SNAP Information Transmittal, to forward the information to the advisor.

TANF

Each Form H2583 requires advisor action:

- If Choices staff receive information that affects an individual's work registration status, they discuss the individual's status with the advisor, or send Form H2583, asking the advisor to reconsider the individual's registration.

  The advisor evaluates the individual's work registration status and changes the work registration code in TIERS, if necessary.

- Information on earned or unearned income requires a budget to determine ongoing eligibility.

  Choices staff attempt to obtain verification from the employer. If the information on Form H2583 is complete and includes the name of the person contacted, use the information for eligibility determination without further verification from the individual.

- Medical or other information affecting Choices participation or designation as a TANF-Basic or TANF-State Program EDG. Review and correct the work registration status or EDG type as needed.

SNAP

Each Form H1817 requires advisor action.

- If E&T staff receive information that affects an individual's work registration status, they send Form H1817 to the advisor asking the advisor to reconsider the individual's registration.

  The advisor evaluates the individual's work registration status and changes the work registration code in TIERS, if necessary.

  If you decide the individual

  - is still subject to work registration, notify E&T staff within 10 days using Form H1817.
  - qualifies for an exemption, do not respond on Form H1817.
- Information on earned or unearned income requires a budget to determine ongoing eligibility.
- Medical or other information affects E&T participation. Review and correct work registration status as needed.

A-1825 Provider Determinations

Revision 23-2; Effective April 1, 2023

SNAP

E&T participants receive services related to one or more SNAP E&T components. These services include supervised job search, vocational training and work experience and are through case management provided by E&T staff or other contracted providers. When E&T staff refer a participant to an E&T component which does not match their needs or skill level, E&T staff enroll the participant in another suitable component fitting the participant's needs or skill level.

If another suitable component is not available, then E&T staff:

- fax form H1816, SNAP E&T Non-Compliance Report, to HHSC specifying an E&T participant received a provider determination; and
- submit a good cause recommendation of 'Other.'

E&T participants cannot be sanctioned for E&T non-participation when no suitable components are available.

When E&T staff send Form H1816 with a provider determination, HHSC staff must approve the request using the good cause system functionality. HHSC staff attempt to contact the SNAP household by phone to:

- explain the provider determination process and the following:
  - a provider determination is used when an E&T component is not a good fit for an E&T participant;
  - the participant is not being sanctioned because of the provider determination; and
  - if the participant is an able-bodied adult without dependents (ABAWD), ABAWD Federal Time Limit (FTL) months will begin counting in the next month.
- explore whether the person is Code E* and obtain verification of the exemption, as described in the SNAP work requirement exemption policy; and
- provide the following contact information:
  - TWC by visiting twc.texas.gov and clicking on the "Find your Local Workforce Solutions Office" or by calling toll-free 800-628-5115; or
  - HHSC by calling 2-1-1 or 877-541-7905 (option 2).

HHSC staff must document if the provider determination information was verbally explained to the SNAP household within 10 days.

If unable to contact the SNAP household by phone, HHSC staff:

- send a Form H1020, Request for Information or Action , to explain the provider determination process;
- request verification of Code E*; and
- provide the following contact information:

- TWC by visiting twc.texas.gov and clicking on the “Find your Local Workforce Solutions Office” or by calling toll-free 800-628-5115; or
- HHSC by calling 2-1-1 or 877-541-7905 (option 2).

*** Code E** means physically or mentally unfit for employment.

Note: ABAWDs do not receive a countable FTL month in any month a provider determination is received. After an ABAWD is notified of a provider determination, FTL months will become countable in the next full benefit month.

Related Policy

Claiming Exemption Due to Disability of Self, A-1822.1.1
Noncooperation with E&T, A-1844
Reasons for Good Cause, A-1861
Counting Months Toward Time-Limited Eligibility, A-1950

A-1830, ESP Actions

Body

Revision 04-3; Effective April 1, 2004

A—1831 Action in Full Service Choices Counties or E&T Counties

Revision 23-3; Effective July 1, 2023

TANF

For households in full service Choices counties:

- provide an explanation of:
  - the Choices program;
  - the supportive services available such as child care, help with transportation expenses related to job search or training, Texas Health Steps and family planning;
  - the person's rights and responsibilities;
  - how both exempt and nonexempt recipients may voluntarily participate and what this means for state time-limited benefits;
  - the full-family sanction for noncooperation for a nonexempt person;
  - transitional childcare and Medicaid; and
  - the requirement to provide proof of identity and work eligibility when requested by HHSC or a Choices provider, and the types of documents accepted as proof. Form H2580, TANF Employment Services Notice, lists examples of proof.

Explain these policies again at periodic review unless the caretaker or second parent show an open Choices case in TIERS inquiry.

Provide a completed Form H2580 for each caretaker and second parent. At the application interview, also provide Form H2580 to the TANF EDG name.

SNAP

Provide a consolidated written notice of the SNAP work requirements, known as SNAP Work Rules, to all non-exempt SNAP work registrants at:

- certification;
- recertification; or
- a change when a household member becomes subject to SNAP work requirements, such as adding a new person to the household or a person in the household turns 18.

The SNAP Work Rules tells each non-exempt SNAP work registrant which work requirements pertain to them, does not apply to persons exempt from Employment and Training (E&T), and is not provided to persons exempt from E&T.

For households in SNAP E&T counties:

- review TIERS correspondences and confirm the household receives the SNAP Work Rules information, included within their TF0001, Notice of Case Action;
- use the SNAP Work Rules — Verbal Informing Script in the related policy section for E&T procedures to verbally explain each registrant’s rights and responsibilities; and

- inform households with members exempt from E&T and of age to participate, that they may voluntarily participate in the E&T Program as described in the related policy about exempt members volunteering to participate in E&T.

If an integrated interview is conducted for a household applying for TANF and SNAP, and the SNAP application is certified while the TANF application remains pending, TIERS assigns SNAP work registration Code Q (Registered with Choices), as if the person were receiving TANF. After staff makes the TANF decision, TIERS changes the SNAP work registration code, if necessary. If a person is registered for SNAP E&T, confirm the household receives the SNAP Work Rules information generated by TIERS within their TF0001, Notice of Case Action.

Related Policy

E&T Procedures, A-1822
Exempt Members Volunteering to Participate in E&T, A-1822.2
State Time Limits, A-2500

A—1831.1 Referral Processes

Revision 12-3; Effective July 1, 2012

TANF

Advisors in full service Choices counties refer TANF applicants to a workforce orientation. This is a separate eligibility requirement from Choices program participation. See Workforce Orientation, A-2200, for more information.

HHSC sends a daily electronic file of all TANF recipients to Choices staff when:

- the TANF EDG is certified; or
- a TANF recipient's work registration code changes.

Non-exempt TANF recipients in full service Choices counties must participate in employment service activities when notified by Choices staff.

SNAP

HHSC sends a daily electronic file of all SNAP recipients to E&T staff when:

- the SNAP EDG is certified; or
- a SNAP recipient's work registration code changes.

E&T staff use this electronic file to register individuals with TWC when the individual:

- lives in an E&T county; and
- is a non-exempt registrant.

Registration is effective for 12 months. At the end of each 12-month period, TWC renews the registrant’s status if the individual is:

- active;
- living in an E&T county; and
- a non-exempt registrant, not identified as an able-bodied adult without dependents (ABAWD).

A—1831.1.1 Choices Outreach

Revision 12-3; Effective July 1, 2012

TANF

TANF or TANF-SP recipients in full service Choices counties whose information is transmitted to the TWC through the daily electronic file may be outreached for Choices services.

Local Workforce Development Boards and TWC access various types of education, training and employment services from local providers, including other state agencies. Services vary depending on an individual's specific needs and the availability of programs in the local area.

A—1831.1.2 ABAWD Referral Process

Revision 24-2; Effective April 1, 2024

SNAP

HHSC sends a daily electronic file of all SNAP recipients, including ABAWDs, to E&T staff. After receiving the electronic file, E&T staff may contact local HHSC staff to obtain SNAP allotment amounts and the number of ABAWDs in the SNAP household.

E&T staff use information provided on the electronic file to outreach the ABAWD for E&T services. If the ABAWD completes the first two weeks of participation in an allowable activity, E&T staff return Form H1822, ABAWD E&T Work Requirement Verification, to HHSC to verify that the ABAWD:

- now meets the SNAP ABAWD work requirement; or
- continues to meet the ABAWD work requirement.

After Form H1822 verifies participation, consider the person as meeting the participation requirements unless:

- E&T staff send Form H1816, SNAP E&T Noncompliance Report, notifying HHSC of noncompliance;
- the person has at least a one-month break in SNAP benefits; or
- the person reports no longer participating.

If an ABAWD does not meet an exception, exemption or the ABAWD work requirement at recertification, HHSC staff must provide Form H1822 to the ABAWD to verify participation during the recertification process. The ABAWD must take Form H1822 to the local workforce center for E&T staff to complete. Either the ABAWD or E&T staff may return the completed Form H1822 to HHSC.

Related Policy

ABAWD Work Requirement, A-1940
Verification Requirements, A-1970
Verification Sources, A-1971

A—1831.2 Individual Participation Requirements

Revision 12-3; Effective July 1, 2012

TANF and SNAP

To comply with participation requirements, the individual must:

- provide supplemental information when requested;
- appear for an interview upon request; and
- report for job interviews and accept an offer of suitable employment.

Note: Streamlined reporting households must respond as directed to all notices and letters from the employment program even if employed.

TANF

To comply with participation requirements, the individual must also:

- participate in activities listed in the employability plan, including keeping appointments, attending training or other education classes, and participating in work experience and job search activities; and
- not voluntarily leave a job unless he has good cause (as interpreted under the Texas unemployment insurance laws).

Exception: Individuals coded P are only required to report their hours.

Individuals may choose to voluntarily withdraw from TANF. Accept Form H1802, Voluntary Withdrawal from Temporary Assistance for Needy Families (TANF), as an individual's intent to withdraw from TANF. When a local eligibility determination office receives a signed Form H1802, follow change procedures in B-600 to:

- process the TANF denial, and
- make changes to the Supplemental Nutrition Assistance Program (SNAP) EDG, if applicable.

When a request to voluntarily withdraw from TANF is received in the same month as a Choices noncooperation, the advisor must send Form TF0001, Notice of Case Action, informing the household of the Choices noncooperation. Open a Choices penalty as listed in A-2144, Imposing a Penalty. The household must reapply in pay for performance.

Note: If Form H1802 sent by the Local Workforce Development Board (LWDB) has not been processed and the individual does not want to withdraw from TANF, notify the LWDB using Form H2583, Choices Information Transmittal, that the individual remains certified for TANF.

Explore the appropriate medical program for each household member. Advisors must provide continuous Medicaid coverage for

- pregnant women and
- children under age one who are eligible through the month of their first birthday.

SNAP

To cooperate with participation requirements, the individual must also cooperate with assigned E&T activities.

A—1832 Action in Minimum Service Choices Counties or Non-E&T Counties

Revision 23-3; Effective July 1, 2023

TANF

In minimum service Choices counties, provide the person a general explanation of:

- employment services available in the area, such as Workforce Innovation and Opportunity Act (WIOA), local Workforce Solutions offices, or Texas Workforce Commission Vocational Rehabilitative services;
- Choices services (if available);
- available supportive services, such as subsidized child care through the local Workforce Development Board; and
- transitional child care and Medicaid.

SNAP

In non-E&T counties, provide the person a general explanation of:

- the types of employment services available in the area, such as those provided through WIOA, local Workforce Solutions Offices, or Texas Workforce Commission Vocational Rehabilitative Services; and
- individual rights and responsibilities outlined in related policy.

Ensure the household receives the SNAP Work Rules information that is included in their TF0001, Notice of Case Action. The SNAP Work Rules information tells each person subject to the work rules which requirements pertain to them. Persons exempt from E&T do not receive the SNAP Work Rules information, and E&T exempt households do not receive work rules information at all.

Related Policy

Individual Responsibilities, A-1832.1

A—1832.1 Individual Responsibilities

Revision 12-3; Effective July 1, 2012

TANF

An individual living in a minimum service Choices county does not have to meet any employment services requirements. Advise the household that they

- are exempt from Choices program requirements;
- may choose whether to participate in Choices services offered to them; and
- will not be penalized for noncompliance if they participate and later stop participating.

See A-2530 for state time limit counting policies for individuals who live in minimum service Choices counties.

SNAP

An individual living in a non-E&T county

- is subject to usual registration requirements;
- must comply with E&T if the county becomes an E&T county and the registrant is contacted; and
- must accept or continue suitable employment, when offered, even if not referred by E&T staff.

A-1840, Noncooperation with ESP

Body

Revision 04-5; Effective July 1, 2004

A—1841 Minimum Penalty Periods

Revision 07-4; Effective October 1, 2007

SNAP

Use the following minimum penalty periods.

If this is the individual's ...	then the minimum penalty period is ...
first noncooperation,	one month or when he cooperates, whichever is longer.
second noncooperation,	three months or when he cooperates, whichever is longer.
third or subsequent noncooperation,	six months or when he cooperates, whichever is longer.

Exception: See Reestablishing Eligibility During the Penalty Period (SNAP) A-1846.

A—1842 Failure/Refusal to Register

Revision 12-3; Effective July 1, 2012

SNAP

If the household member who fails to furnish all information needed to register is:

- the primary wage earner (PWE), deny the EDG.
- a member who is not the PWE, disqualify the individual.

See Minimum Penalty Periods, A-1841.

Exception: For expedited applications:

- postpone work registration if necessary, for members not present at the interview until after the household receives its first month's benefits (or first two months if you issue a combined allotment); and
- take adverse action for the second month (or third month if you issue a combined allotment) if all required registrants fail to provide the necessary information.

A—1843 Noncooperation with Choices

Revision 17-2; Effective April 1, 2017

TANF

Choices staff determine when a nonexempt individual fails without good cause to cooperate with Choices requirements. They use Form H2581, Choices Noncooperation Report, to notify advisors the date they made the noncooperation decision.

Failure to cooperate with Choices requirements results in:

- a full-family sanction for one month or until cooperation, whichever is longer; and
- denial of the TP 08 EDG for TANF recipients also certified for TP 08 benefits.

Related Policy

Completing the Penalty Action, A-1845.2
Imposing a Penalty, A-2144

A—1843.1 TANF-SP Procedures

Revision 12-3; Effective July 1, 2012

TANF

If a nonexempt parent in a full service Choices county fails to cooperate, apply a full-family sanction for one month or until cooperation, whichever is longer.

A—1844 Noncooperation with E&T

Revision 21-2; Effective April 1, 2021

SNAP

E&T staff determine when a person fails to cooperate with employment services requirements. E&T staff send noncompliance information electronically through the automated interface to notify HHSC of the person's failure to cooperate. E&T staff may send Form H1816, SNAP E&T Noncompliance Report, to HHSC staff with more details.

If a PWE fails to cooperate with employment services requirements, Choices requirements or with work requirements in TWC's unemployment insurance program without good cause, the household is ineligible for the minimum penalty periods.

If a person who is not the PWE fails to cooperate without good cause, disqualify the person for the applicable minimum penalty period.

Note: If the noncooperating person moves to a new household:

- deny the new household for the remainder of the penalty period if the person is the new household's PWE; or
- disqualify the person for the remainder of the penalty period if the person is not the new household's PWE.

The following procedures apply to a household with a person who is:

- exempt from registration due to TANF-Choices status or due to applying for or receiving unemployment insurance benefits (UIB); and
- penalized in that program for not cooperating with a program requirement.

When an individual fails to cooperate with ...	then ...
a Choices requirement in TANF,	apply the E&T noncooperation penalty unless the person is exempt for another reason.
a work requirement in TWC's UIB program,	apply the E&T noncooperation penalty unless the person is exempt for another reason.

A disqualified person may re-establish eligibility after the minimum penalty period expires. A person may re-establish eligibility during the penalty period by becoming exempt from E&T registration.

Related Policy

E&T Exemptions, A-1822 .1
Minimum Penalty Periods, A-1841
Re-establishing Eligibility During the Penalty Period, A-1846
Re-establishing Eligibility After the Penalty Period, A-1847
Determining Good Cause, A-1860

A—1844.1 Determining Primary Wage Earner (PWE) for Noncooperation Situations

Revision 13-3; Effective July 1, 2013

SNAP

Determine a household's PWE as follows:

If ...	then the ...
(a) the household includes: • a parent of a child of any age living in the home; or • an adult with parental control of a child under age 18 living in the home,	household selects the PWE and all adult members must agree to the selection. The PWE selected must: • be an adult parent of a child of any age; or • have parental control of a child under age 18 living in the home. The household must select a PWE at certification, recertification, or when household composition changes.
(b) adult household members cannot agree on a PWE, or Item (a) does not apply,	PWE is the member (including a disqualified member) who: • earned the most income in the two months before the month of noncooperation; and • was employed at least 20 hours per week at the federal minimum wage or had earnings equal to this amount.

If ...	then the ...
(c) a PWE cannot be designated using the criteria in Item (a) or (b) above,	PWE is the member listed as head of household on the noncooperation date.

Exception: For Items (b) and (c) in the chart above, a person (any age) may not be the PWE if he lives with his parent (or person fulfilling the role of his parent) who is:

- registered for work through the SNAP E&T program (even if he has a participation exemption); or
- exempt from registration due to employment, TANF-Choices status, or receipt/application for UIB.

The household can change the PWE during the certification period. Exception: The household cannot change the PWE if the current PWE has failed to cooperate with SNAP E&T requirements or has voluntarily quit a job, unless a new member has joined the household and is selected as the PWE.

A—1844.2 Tracking the Number of Sanctions

Revision 14-4; Effective October 1, 2014

SNAP

Document in the case record each time the individual is sanctioned for:

- employment services,
- voluntary quit,
- voluntarily reducing work hours,
- Choices, or
- unemployment insurance.

A sanction for any of these work requirements counts as a noncooperation penalty.

Example: The individual has one sanction for voluntary quit without good cause. The individual served a one-month penalty and obtained a comparable job. The individual was laid off and was registered with the E&T program. The individual noncooperated with one of the E&T requirements. This is the second sanction.

A—1845 Action on Noncooperation

Revision 05-3; Effective July 1, 2005

A—1845.1 Sending Notice of Failure to Cooperate

Revision 23-3; Effective July 1, 2023

TANF

When a certified household member does not cooperate with a Choices requirement, send Form TF0001, Notice of Case Action, within five workdays after receiving notice of Choices noncooperation. Provide the person with adequate notice of adverse action. Send Form H2581, Choices Noncooperation Report, electronically through the automated interface to inform TWC staff of the sanction effective date.

SNAP

When a certified household member does not cooperate with E&T, send Form H1818, Failure to Comply with SNAP Employment and Training, within one business day of receiving notice of E&T noncooperation. Allow the person 10 days to contact TWC staff and claim good cause for the noncompliance.

HHSC allows three additional days beyond the 10-day period before issuing a TF0001, Notice of Case Action, to give sufficient time for TWC staff to send good cause information to HHSC. If HHSC does not receive a good cause claim within the 13-day period, send Form TF0001 by the next business day. Provide the person advance notice of adverse action. Ensure TIERS sends Form H1808, Agreement to Follow SNAP Rules, with the TF0001. The disqualified person or household may comply as early as the last month of the penalty period by signing the Form H1808, and could regain eligibility as early as the following month.

A household denied due to the PWE's disqualification must file a new application to re-establish eligibility but may do so the last month of the penalty period with eligibility potentially beginning the month after.

If HHSC receives good cause from TWC within the 13-day period, follow policy to determine good cause.

Exception: E&T noncooperation notices received in the last benefit month require enough notice of adverse action.

Send Form H1818 to explore good cause even if the EDG is denied, if the noncooperation occurred during a month in which the person received SNAP and was required to participate in E&T.

Related Policy

Re-establishing Eligibility After the Penalty Period, A-1847
Determining Good Cause, A-1860
Appeals, A-1870
How to Take Adverse Action if Advance Notice is Required, A-2341.1

A—1845.1.1 Failing to Timely Send Notice of Adverse Action

Revision 12-3; Effective July 1, 2012

SNAP

If E&T staff fail to timely notify HHSC of a noncooperation or the advisor fails to send notice of adverse action, the advisor must send the notice of adverse action as soon as possible after discovering the error. Do not file a claim.

TANF

If HHSC does not take action on a noncooperation report within a reasonable time frame, send Form TF0001, Notice of Case Action, to initiate the noncooperation sanction as soon as possible.

Form TF0001 is sent within a reasonable time frame if the:

- Choices penalty is received within five calendar days after the end of the month in which the Choices noncooperation occurred; and
- advisor sends Form TF0001 within 10 calendar days after becoming aware of the noncooperation or within the same calendar month as the date of noncooperation listed on the Choices noncooperation notice.

If the advisor does not send Form TF0001 within a reasonable time frame, the first month of noncooperation is the month Form TF0001 was sent. Do not file a claim.

Note: A postponed first month results in a forfeit month, but does not count toward two consecutive months of noncooperation. See A-2141.1, Determining the First Month of Noncooperation.

A—1845.1.2 Failing to Impose a Penalty After Providing Notice of Adverse Action

Revision 23-1; Effective Jan. 1, 2023

TANF and SNAP

When a notice of adverse action for noncooperation is sent but the penalty is not imposed for the correct month:

- for SNAP, file a claim for any months received in error; and
- for TANF, determine the actual first and second month of noncooperation. If the person:
  - cooperates in the second month, file a claim for the month that should have been forfeited. The household is not required to reapply for TANF.
  - fails to cooperate in the second month, file a claim for the months that should have been forfeited. The household must reapply in pay for performance.

A—1845.1.3 Penalty is not Applicable

Revision 12-3; Effective July 1, 2012

TANF and SNAP

Do not send Form TF0001, Notice of Case Action, and take adverse action if:

- the individual was exempt at the time Choices or E&T staff made the noncooperation decision. Change the individual's work registration code as appropriate and do not take adverse action.
  - Send Form H2581 to notify Choices staff that the individual was exempt at the time of noncooperation, which you will not impose the sanction and the noncooperation does not count.
  - Do not respond to E&T sanctions.

- Choices or E&T noncooperation month is after the effective date of the denial. There is no penalty since the individual was not a recipient for that month.
  - For TANF EDGs, send Form H2581 to notify Choices staff that since the individual was not certified at the time of noncooperation, you will not impose a sanction and the noncooperation does not count.
  - For SNAP EDGs, do not send a response to E&T staff.

A—1845.2 Completing the Penalty Action

Revision 12-3; Effective July 1, 2012

TANF

Complete the penalty action as follows.

If the caretaker or second parent noncomplies:

- ensure there is a signed Form H1073, Personal Responsibility Agreement, for the EDG;
- do not establish a protective payee;
- change the work registration code to W.

For each caretaker and second parent who noncomplies with Choices, advisors must enter start dates (and end dates, if applicable) for a Choices penalty.

SNAP

Complete the penalty action as follows.

- If the noncomplying member is the PWE, change his work registration code to U (Primary wage earner failed to comply with ESP) and deny the EDG.
- If the noncomplying member is not the PWE, disqualify him and change the work registration code to Code T (Disqualified household member).

Note: See A-1841, Minimum Penalty Periods.

A—1846 Re-establishing Eligibility During the Penalty Period

Revision 14-4; Effective October 1, 2014

SNAP

An individual disqualified for an E&T noncompliance or a household denied because the PWE failed to comply with E&T may re-establish eligibility during the penalty period if the noncomplying individual becomes exempt from E&T registration.

A household denied because the PWE failed to comply with E&T may also re-establish eligibility if:

- the PWE leaves the home, or
- a new individual joins the household who would have been the PWE. If the household is otherwise eligible, certify the household and disqualify the previous PWE for the remainder of the penalty period.

When an individual disqualified for an E&T noncompliance on an active SNAP EDG re-establishes eligibility by becoming exempt, end the disqualification effective the first day of the month after the individual provides the information/verification required to qualify for the exemption. A household denied due to an individual's E&T noncompliance must file a new application to re-establish eligibility and is eligible from the file date if all required information/verification is provided by the final due date.

When a household is denied because the PWE did not comply with E&T requirements, the disqualified household may apply and be interviewed for SNAP during the last month of the E&T penalty period.

A—1847 Re-establishing Eligibility After the Penalty Period

Revision 23-3; Effective July 1, 2023

TANF

See the related pay for performance policy to determine the appropriate action to take when a person has an open penalty at reapplication.

SNAP

A disqualified person cannot become eligible until after the minimum penalty period expires or the person meets an exception described in the related policy about re-establishing eligibility during the penalty period.

Unless exempt, the person must sign Form H1808, Agreement to Follow SNAP Work Rules, to agree to participate with E&T. Add the household member to the EDG after the person signs Form H1808.

If the minimum penalty period has expired, end the non-PWE's disqualification effective the first day of the month after the disqualified person signs Form H1808 agreeing to comply.

Notes:

- The disqualified person may comply in the last month of the penalty period and be added the first day of the next month.
- A denied household may file a new application and be certified in the last month of the penalty period but the household cannot receive SNAP for any month the household was previously disqualified.
- If a denied household reapplies after the penalty period has ended, certify from the file date and not the date the person signed Form H1808.
- A denied household that meets expedited criteria and includes more than one disqualified person who has served the minimum disqualification period at the time of the application may choose to:
  - delay the certification until all disqualified individuals have signed Form H1808; or
  - receive expedited benefits for the PWE and any person who has signed Form H1808 at the time of the interview. Any additional disqualified persons will be added to the SNAP household using change-processing procedures. Add additional persons the month after they provide the signed Form H1808.

Related Policy

Re-establishing Eligibility During the Penalty Period, A-1846
Pay for Performance, A-2150

A-1850, Voluntary Quit

Body

Revision 05-3; Effective July 1, 2005

SNAP

If an applicant or participating household reports the loss of earned income or reduction in work hours to less than 30 hours a week, determine whether the household member voluntarily quit his job or reduced his work hours.

Note: See A-2123 for TANF Voluntary Quit policy.

A—1851 Applying Voluntary Quit

Revision 13-3; Effective July 1, 2013

SNAP

Voluntary quit procedures apply to:

- any local, state, or federal government employee who loses his job because he participates in a strike;
- a person who leaves a job unannounced or does not return to work without good cause, even if he technically was fired; or
- a person who voluntarily reduces his work hours to less than 30 hours a week.

Voluntary quit procedures do not apply to people who

- are exempt from E&T registration;
- end a self-employment enterprise;
- resign a job at the employer's demand; or
- are currently on strike.

A—1851.1 How to Determine if Voluntary Quit Applies

Revision 13-3; Effective July 1, 2013

SNAP

-	Yes	No
1. Has a household member (including a disqualified member) quit a job or reduced his hours of employment to less than 30 hours a week within 60 days before the application date or anytime after?	For quits, go to Step 2. For reduction of work hours, go to Step 3.	Not applicable. Stop.
2. Did the job involve at least 30 hours per week at federal minimum wage or equivalent earnings?	Go to Step 3.	Not applicable. Stop.
3. Did the person have good cause for quitting his job or reducing his work hours?	Not applicable. Stop.	Go to Step 4.
4. Was the person exempt from E&T on the quit date or date hours were reduced?	Not applicable. Stop.	Go to Step 5.
5. The voluntary quit penalty applies.		

A—1852 Determining PWE for Voluntary Quit Situations

Revision 13-3; Effective July 1, 2013

SNAP

Determine a household's primary wage earner as follows:

If ...	then the ...
(a) the household includes • a parent of a child of any age living in the household, or • an adult with parental control of a child under age 18 living in the household,	household may select the PWE. All adult members must agree to the selection. The PWE selected must: • be an adult parent of a child of any age, or • have parental control of a child under age 18 living in the household. A selection must be made at certification, recertification, or when household composition changes.
(b) adult household members cannot agree on a PWE, or Item (a) does not apply,	PWE is the member (including a disqualified member) who earned the most income in the two months before the month of quit if he was: • otherwise required to register on the quit date (interview date for applicants), and • employed at least 20 hours per week at the federal minimum wage or had earnings equal to this amount.
(c) a PWE cannot be designated using the criteria in Item (a) or (b) above,	PWE is the head of household on the quit date (for active EDGs only) if he was required to register on the quit date (or would have been if not disqualified).

Exception: For Items (b) and (c) in the chart above, a person (any age) may not be considered the primary wage earner if he lives with his parent (or person fulfilling the role of his parent) who is:

- registered for work through the SNAP E&T program; or
- exempt from registration.

The household can change the PWE during the certification period.

Exception: The household cannot change the PWE if the current PWE has failed to cooperate with SNAP E&T requirements or has voluntarily quit a job, unless a new member has joined the household and is selected as the PWE.

A—1853 Advisor Action on Voluntary Quit or Reduction in Work Hours

Revision 23-3; Effective July 1, 2023

SNAP

If you discover the quit ...	then ...	
before completing certification,	apply the sanction using the penalty periods found in the related minimum penalty period policy.	
after certification and early enough to prevent issuance of the last month's benefits,	apply the sanction using minimum penalty periods. Start the sanction the first month after the adverse action notice period ends.	
too late in the certification period to prevent issuance of the last month's benefits,	if the household ...	then...
-	reapplies before the end of the certification period,	apply the penalty. Notify the household on Form TF0001, Notice of Case Action, that the penalty period starts the first month of the new certification period.
-	does not reapply by the last day of the certification period,	on the last day of the certification period send Form TF0001 to notify the household of the sanction period beginning with the month after the old certification period expires.

If the primary wage earner (PWE) noncomplies, deny the EDG.

If the non-PWE noncomplies, disqualify the non-PWE and change the person's work registration code to Code T (Disqualified household member). Send Form TF0001 by the next business day. Provide the person advance notice of adverse action.

For voluntary quit, ensure TIERS sends Form H1808, Agreement to Follow SNAP Rules, with the TF0001. Add comments to the TF0001 that the disqualified person or household may comply as early as the last month of the penalty period by signing the Form H1808 and could regain eligibility as early as the month after that.

A household denied due to the PWE's voluntary quit must file a new application to re-establish eligibility but may do so the last month of the penalty period with eligibility beginning the month after.

If the PWE moves to another household and would have been the PWE, deny that household for the remainder of the penalty period. If the PWE moves, but would not have been the PWE of the new household, disqualify the person for the remainder of the penalty period.

If the person quits or voluntarily reduces work hours without good cause but does not report it or HHSC does not act timely, apply the penalty as soon as possible after the adverse action notice expires.

Related Policy

Minimum Penalty Periods, A-1841
Tracking the Number of Sanctions, A-1844.2

A—1854 Re-establishing Eligibility During the Penalty Period

Revision 13-3; Effective July 1, 2013

SNAP

A person or household, disqualified or denied because of a voluntary quit or a reduction in work hours, may re-establish eligibility during the penalty period if the non-complying member becomes exempt from E&T registration.

A household denied because the PWE voluntarily quit a job, or voluntarily reduced work hours, may also re-establish eligibility during the penalty period if:

- the PWE leaves the home; or
- a new member joins the household who would have been the PWE. If the household is otherwise eligible, certify it and disqualify the old PWE for the remainder of the penalty period.

A—1855 Re-establishing Eligibility After the Penalty Period

Revision 23-3; Effective July 1, 2023

SNAP

To re-establish eligibility after the penalty period for a voluntary quit, the disqualified PWE or non-PWE must:

- become exempt from E&T registration;
- agree to comply by signing Form H1808, Agreement to Follow SNAP Work Rules; or

- get a new job comparable to the one the person quit. Consider a job comparable if it involves one of the following:
  - equal or increased salary or hours; or
  - fewer hours or lower net salary, with the person's statement that the new job offers better chances to improve job skills or provide advancement opportunities.

To re-establish eligibility after the penalty period for voluntarily reducing work hours, the person must:

- become exempt from E&T registration; or
- return to work for 30 or more hours a week.

End the disqualification effective the first day of the month after the person complies or becomes exempt if the minimum penalty period has ended.

Notes:

- The disqualified person may comply in the last month of the penalty period and be added to the SNAP household the first day of the next month.
- A denied household may file a new application and be certified in the last month of the penalty period, but the household is not eligible for SNAP for any month the household was previously disqualified.

A-1860, Determining Good Cause

Body

Revision 23-3; Effective July 1, 2023

TANF

If the person claims good cause for failing to respond to outreach during the adverse action period and provides a reasonable explanation:

- Use Form H2581, Choices Noncooperation Report, to refer the person to TWC staff for a determination.
- Provide continued benefits if TWC staff provide notice of good cause before the notice period expires.

For other good cause claims, the person must file an appeal to receive a determination.

The Choices automated interface sends TIERS a good cause code with start or end dates. Do not set a good cause start or end date.

If a person has an open Choices penalty, the Choices automated interface may send TIERS a good cause start date. Remove the Choices penalty if TWC staff send good cause during the first noncooperation month. Good cause sent during the second noncooperation month verifies cooperation. Reinstate benefits after the forfeit month.

SNAP

Determine good cause for:

- voluntary quit noncompliance;
- any E&T registrant whose unemployment insurance benefits (UIB) are lowered or denied because of noncompliance with the UIB program; and
- noncompliance with the E&T program.

The Texas Workforce Commission (TWC) collects good cause information from people who fail to comply with the E&T program and sends all good cause claims received to HHSC through an automated interface. Additionally, a person can contact HHSC to claim good cause for not complying with E&T requirements.

Staff must review good cause claims and determine whether the person had good cause for the noncompliance. A person has 10 calendar days to claim good cause after HHSC sends the Form H1818, Failure to Comply with SNAP Employment and Training, to the household. A person can also claim good cause during the adverse action period.

Review the case facts and circumstances when evaluating a good cause claim. If the person has an allowable good cause reason do not impose the E&T sanction. If unable to determine whether the person’s claim meets the definition of good cause or if the good cause claim is questionable, request more information from the household. If the person does not respond within 10 calendar days, deny the good cause claim and impose the E&T sanction.

Related Policy

Noncooperation with E&T, A-1844
Sending Notice of Failure to Cooperate, A-1845.1
Reasons for Good Cause, A-1861

Continued Benefits, B-1051
Questionable Information, C-920

A—1861 Reasons for Good Cause

Revision 23-1; Effective Jan. 1, 2023

SNAP

Good cause exists when circumstances beyond the applicant's control prevent them from complying with employment services requirements.

Good cause includes, but is not limited to, the following:

- unavailability of care for children 6 through 11 based on the person's statement;
- discrimination by an employer based on age, race, sex, color, handicap, religious belief, national origin or political beliefs;
- work demands or conditions making continued employment unreasonable (example: not being paid on time);
- the person is a survivor of family violence;
- unavailability of transportation;
- a change of job;
- illness of the person or another household member;
- at least half time enrollment in a recognized school, training program, or institution of higher education requiring the primary wage earner to quit a job;
- household emergency;
- a work schedule conflict preventing the person from participating in E&T;
- relocation to another county or political subdivision because of another household member's employment or school enrollment;
- resignations by people under 60 years old that the employer recognizes as retirement;
- a job change that does not happen or results in employment of less than 20 hours a week or weekly earnings of less than the federal minimum wage multiplied by 20 hours;
- a habitual job change (example: migrant work or construction habitually require workers to move from one employer to another); or
- an unsuitable job. Employment is unsuitable if the:
    - wages are less than the highest of:
        - the applicable federal minimum wage; or
        - 80 percent of the federal minimum wage, if the federal minimum wage is not applicable; or
    - average hourly wage based on piece-rate is less than minimum wage;
    - household member must join, resign from or not join a labor organization as a condition of employment; or
    - work is at a place subject to a strike or lock-out at the time of the offer with these exceptions:
        - the strike was enjoined under Section 208 of the Labor Management Relations Act (29 U.S.C. 178); or
        - an injunction was issued under Section 10 of the Railway Labor Act (45 U.S.C. 160);
    - degree of risk to health and safety is unreasonable;
    - household member is physically or mentally unfit for the job;
    - commuting time from the household member's home to the job is more than two hours a day (taking a child to and from a child care facility is not included);
    - distance from home to the job is unreasonable because, after considering commuting time and costs, the person earns less than minimum wage;
    - distance to the job prohibits walking and transportation is unavailable;
    - working hours or nature of the employment interferes with the member's religious beliefs; or
    - job is outside the person's usual line of work (this applies only during the first 30 days of registration and does not apply if the person voluntarily quits a job.)

A-1870, Appeals

Body

Revision 23-3; Effective July 1, 2023

TANF and SNAP

A person is entitled to a hearing to contest the:

- decision not to allow an exemption; and
- denial or reduction of benefits because of noncompliance.

TANF

If, during the adverse action notice period, the person appeals a noncompliance penalty:

- process the request;
- update the work registration code as Code K to indicate the person is appealing the Choices sanction; and
- provide continued benefits, if applicable, following procedures in the related policy about handling benefits during the appeal process. The person may choose to waive the right to continued benefits instead.

The hearing officer notifies both HHSC staff and Choices staff about the hearing date and the Choices noncompliance appeal decision.

If the person requests continued benefits and the hearing officer sustains the decision, change the work registration status from "appeal pending with Choices" (Code K) to "sanctioned for Choices nonparticipation" (Code W) to show the person is sanctioned. Then:

- add the penalty with the original penalty start date;
- file a claim to recover benefits for the months the person received continued benefits; and
- deny the EDG as explained in the related full family sanction policy, if the household failed to cooperate with the Personal Responsibility Agreement for two consecutive months.

If the hearing decision was reversed, enter the appropriate work registration status in TIERS.

SNAP

If the person appeals the noncompliance penalty during the adverse action advance notice period:

- process the appeal request for:
  - voluntary quit or reduction in hours; or
  - noncompliance with E&T. The hearing officer notifies both the HHSC staff and TWC staff of the hearing date.
- provide continued benefits following procedures in the related continued benefits policy, unless the person waives the right to continued benefits.

Note: If someone appeals a first offense, offer the person an opportunity to sign Form H1808, Agreement to Follow SNAP Work Rules, before the end of the one-month minimum penalty period.

If the person requests continued benefits and the hearing officer sustains the decision:

- impose the penalty for the remaining number of months, if appropriate;
- update the E&T penalty counter on an active EDG after the penalty expires, if appropriate; and
- file a claim to recover benefits for the months the person received continued benefits.

Related Policy

Full-Family Sanction, A-2140
Handling of Benefits During the Appeal Process, B-1050
Continued Benefits, B-1051

A-1880, Verification Requirements

Body

Revision 22-1; Effective, January 1, 2022

TANF

Verify all exemptions.

SNAP

Verify:

- exemptions that are questionable;
- that a member is physically or mentally unfit for employment (Code E) if the disability is not obvious;
- that a parent or other household member is caring for a disabled person of any age living in the household (Code H); and
- that a refugee is participating at least half-time in a training program administered by a refugee contractor or Match Grant Program (Code S).

Related Policy

SNAP Work Requirement Exemptions, A-1822.1
Verification Requirements, A-1640

A—1881 Verification Sources

Revision 16-4; Effective October 1, 2016

SNAP and TANF

Acceptable forms of verification must state self-employment hours worked. Acceptable forms of verification include:

- business records and receipts;
- checks;
- tax records;
- a statement from a knowledgeable source; and
- acceptable verification for self-employment income described in A-1370, Verification Requirements, except for the Form H1049 (PDF) and client statement.

A-1890, Documentation Requirements

Body

Revision 26-1; Effective Jan. 1, 2026

TANF

Document:

- how you verified exemptions;
- failure to comply; and
- penalty information from the automated Texas Workforce Commission (TWC) interface or Form H2581, Choices Noncooperation Report, including the noncooperation date, applicable penalty period and reason when a Choices penalty is not entered in the automated system.

SNAP

Document:

- all exemptions;
- that all exempt household members were informed about the E&T program, that they can participate as a volunteer, and were provided with the TWC contact information;
- that households with a combination of mandatory and voluntary E&T participants were screened for appropriateness, informed they must participate in the E&T program, explained the SNAP Work Rules — Verbal Informing Script, and provided a consolidated written notice of the SNAP work requirements.
- failure to comply;
- penalty information from the automated TWC interface or Form H1816, SNAP E&T Noncompliance Report including the noncooperation date, applicable penalty period and reason when the SNAP E&T penalty does not generate with the automated system;
- voluntary quit or reduction of work hours;
- good cause for failure to comply and voluntary quit or reduction of work hours;
- the selection or non-selection of a primary wage earner (PWE) at application, recertification and when household composition changes; and
- which option the household chose when reapplying for and meeting expedited criteria once members disqualified for E&T served the minimum penalty period.

Related Policy

The Texas Works Documentation Guide

A-1900, Federal Time Limits

A-1910, General Policy

Body

Revision 24-4; Effective Oct. 1, 2024

TANF and SNAP

Federal legislation requires certain people receive benefits for a limited number of months.

TANF

A household with a caretaker or second parent is limited to receiving TANF for 60 months. Each caretaker and second parent have their own separate TANF federal time limit (FTL). When the caretaker or second parent reaches the 60th month of their TANF FTL, deny the entire household at the end of the 60th month.

Benefits received as an eligible child do not count toward their TANF FTL if the child is later certified as a caretaker or second parent. A child who is certified on a TANF EDG that reaches their TANF FTL may continue to receive TANF if certified with a different caretaker or payee who has not reached their TANF FTL.

Note: Do not count TANF-SP benefits toward a caretaker's or second parent's 60-month TANF FTL.

SNAP

An able-bodied adult without dependents (ABAWD) is any person who is age 18 through 54 without dependents in their SNAP household. ABAWDs must meet the ABAWD work requirement by working at least 80 hours in a 30-calendar day period unless they meet exception criteria. ABAWDs who do not meet the work requirement are initially limited to receive three months of SNAP benefits in a 36-month period. The 36-month period begins the first month an ABAWD fails to meet the ABAWD work requirement.

Related Policy

ABAWD Referral Processes, A-1831.1.2
SNAP ABAWD Work Requirements, A-1940
Regaining Eligibility, A-1960
TANF-SP 60-Month Time Limit, A-2560

A-1920, Determining the Number of FTL Months Used

Body

Revision 11-3; Effective July 1, 2011

TANF

Effective with October 1999 benefits, each month a caretaker or second parent receives a TANF benefit counts toward the FTL, even if the month does not count toward the state time limit. This includes TANF benefits received in another state. Additionally, any month these members received benefits in Texas from November 1996 through September 1999 that counted toward the **state** time limit, also counts toward the FTL. **Note:** Individuals in control group cases were subject to FTLs beginning with October 1999 benefits.

Do not count a month toward the FTL if

- a caretaker or second parent is disqualified.
- the household's grant is:
  - cancelled and not reissued,
  - cancelled and reissued without including the caretaker or second parent's needs,
  - totally claimed as an overpayment.

A—1921 Tracking FTL Months

Revision 17-3; Effective July 1, 2017

TANF

Effective Oct. 1, 1999, an FTL month counts when a TANF benefit is issued to an adult caretaker or second parent.

To count a month an individual received benefits in another state, enter information in TIERS Data Collection – Out-of-State Benefits. FTL months only count if the individual received cash assistance. TIERS programming correctly determines FTL months for each individual. FTL information transferred from SAVERR during TIERS conversion. Advisors must contact the IEE/TIERS Technical Help Desk if FTL months need to be corrected in TIERS.

FTL months and years counted towards an individual’s FTL can be found in TIERS on the TANF Time Limit page.

TIERS inquiry displays FTL data on the Individual – TANF Time Limits & PRA screen in the hover menu. It includes the:

- maximum months;
- FTL months used; and
- remaining months available.

A-1930, Extended TANF and Hardship Exemptions

Body

Revision 06-4; Effective October 1, 2006

A—1931 General Policy

Revision 03-5; Effective July 1, 2003

TANF and TANF-SP

Federal law allows exemption from the 60-month lifetime limit due to hardship. Extended TANF is the TANF and TANF-SP cash assistance program beyond the 60-month lifetime limit. A caretaker or second parent can apply for extended TANF and a hardship exemption at any time during or after their 60th month of assistance.

A—1932 Eligibility Requirements

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

A caretaker or second parent may submit an application for extended TANF during their 60th month of lifetime TANF benefits, or after. They must:

- have fewer than 12 months of open Choices or child support penalties during a benefit month since Nov. 1, 1996;
- have a qualifying hardship exemption (see A-1933, Hardship Exemptions); and
- meet regular TANF eligibility criteria.

Note: Choices or child support penalty months may not be counted twice, if both penalties are open during the same month.

Review the extended TANF hardship exemptions with the applicant to identify the hardship. If the family qualifies under more than one hardship, the advisor and applicant should decide which hardship exemption is best for the household. After determining that the family meets extended TANF criteria, follow regular TANF eligibility requirements and program policies to determine eligibility.

As a condition of eligibility, require the extended TANF applicant to sign a new Form H1073, Personal Responsibility Agreement, and attend a Workforce Orientation refresher course, even if there is no break in benefits. Extended TANF caretakers and second parents are subject to the same Choices work requirements and exemptions as a regular TANF recipient.

The household is permanently ineligible from receiving TANF benefits when an individual non-complies with Choices or child support requirements after certification for extended TANF.

A—1933 Hardship Exemptions

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

The extended TANF applicant must have one of the following hardships:

1. **Personal Disability** – A personal mental or physical disability expected to last more than 180 days.
2. **Caring for a Family Member with a Disability** – Responsible for the care of a family member with a disability for more than 180 days.
3. **Family Violence** – Victim of family violence.
4. **Residence in a Minimum Service Choices County**– Resided in a minimum l service Choices county
    - during the 60th month of the initial 60-month period, or
    - at any time during the 11 countable months immediately preceding the 60th month.
5. **Lack of Employment** – The caretaker or second parent complied with Choices requirements with no more than one Choices penalty since November 1, 1996, but is unable to obtain sufficient employment during the last 12 consecutive months before the end of the 60-month time limit. The individual cannot qualify for this hardship if the lack of sufficient employment during the last 12-month period resulted from voluntarily quitting a job.

Note: Caretakers and second parents who qualify for extended TANF for reasons 4 (Residence in a Minimum Service Choices County) and 5 (Lack of Employment) are limited to a total of 24 cumulative months of benefits. Good cause and Choices exemption months count toward the 24-month limit.

A—1933.1 Advisor Action at Application

Revision 13-2; Effective April 1, 2013

A—1933.1.1 Personal Disability

Revision 14-3; Effective July 1, 2014

TANF and TANF-SP

The caretaker or second parent may qualify for the personal disability exemption if the individual:

- provides a completed Form H1836-A, Medical Release/Physician's Statement, dated no more than six months before the application month. Form H1836-A must establish that the disability is expected to last more than 180 days.
- is certified to receive HHSC Long-term Services and Supports.
- is certified for Supplemental Security Income (SSI).

If the caretaker or second parent is not certified for SSI, inform the caretaker or second parent claiming the disability that the individual must apply for SSI before the next complete review. Follow policy in A-1311.1, Requirement to Pursue SSI/RSDI.

Exception: An SSI application is not required if the applicant has an SSI application pending or previously applied for SSI and was denied within the last 12 months. If the SSI denial was more than 12 months before the extended TANF application month, a new SSI application is required. Inform the individual that this exemption must be re-evaluated at the next periodic review.

A—1933.1.2 Caring for a Family Member With a Disability

Revision 14-3; Effective July 1, 2014

TANF and TANF-SP

The caretaker or second parent may qualify for the caring for a family member with a disability exemption if the caretaker or second parent:

- provides a completed Form H1836-B, Medical Release/Physician's Statement, that is no more than six months old. Form H1836-B must establish that the family member's disability is expected to last more than 180 days and that the applicant is needed in the home to care for the family member with a disability.
- is listed as the primary caregiver in the care plan for the family member with a disability, for family members receiving HHSC Long-term Services and Supports.
- provides a completed Form H1836-B that is no more than six months old and indicates the applicant is needed in the home to care for the family member certified for SSI.

Refer to Step 2 of A-2543.2.2, Disabling Illness or Injury of Close Family Member, to determine the degree of relationship that applies. The degree of relationship that applies to state time limits applies to FTLs.

If the family member with a disability is not already approved for SSI, inform the person caring for the family member with a disability that the family member with a disability must apply for SSI before the next complete review. Follow policy in A-1311.1, Requirement to Pursue SSI/RSDI.

Exception: An SSI application is not required if the family member with a disability has an application pending or previously applied for SSI and was denied within the last 12 months. If the SSI denial was more than 12 months before the application month, a new SSI application is required. Inform the individual that this exemption must be re-evaluated at the next periodic review.

A—1933.1.3 Family Violence

Revision 13-4; Effective October 1, 2013

TANF and TANF-SP

If the applicant indicates on Form H1713, Service Plan for Family Violence Option and Report of Good Cause, that the individual is a victim of family violence, make an assessment referral to the family violence program specialist following policy in A-1131.1, Good Cause for Family Violence Option. A list of Family Violence Shelters is located at www.hhsc.state.tx.us/Help/family-violence/centers.shtml. The family

violence specialist makes a recommendation about the claim. If the family violence specialist establishes that the applicant is a victim of family violence, the applicant is eligible for the exemption.

A—1933.1.4 Residence in a Minimum or Mid-Level Service County

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

Verify that the applicant resided in a county that offered only minimum or mid-level Choices services during at least one of the last 12 countable months of the individual's 60-month period by reviewing the applicant's residence history. Contact the Local Workforce Development Board (LWDB) to verify the county's service level status during those 12 countable months.

Example: The applicant reached her 60th month of TANF assistance in January. She is applying for extended TANF in July and currently resides in a full-service county but claims that no Choices services were available in her county when she was receiving regular TANF benefits. Verify the applicant's county of residence over the last 12 countable months of her 60-month period. Determine the county's Choices service level status during those months by contacting the local board.

The applicant meets this exemption criteria if the individual resided in a minimum service Choices county in any month during the entire last 12 countable months of her 60-month time limit.

A—1933.1.5 Lack of Employment

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

The applicant must have

- no more than one Choices penalty during the individual's 60-month time limit; and
- been unable to obtain sufficient employment during the last 12 consecutive months before the end of his 60-month time limit. Count back 12 calendar months from the 60th month. The 60th month is month one of the 12 months.

Note: The individual cannot qualify for this hardship if the lack of sufficient employment during the last 12-month period resulted from voluntarily quitting a job.

A—1933.2 Advisor Action at Complete Review

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

At each complete review after initial certification for extended TANF benefits, advisors must verify that the individual continues to meet

- the hardship criteria for extended TANF benefits due to a disability, caring for a member with a disability, or family violence; and
- all other TANF eligibility requirements.

Advisors are not required to re-verify hardship due to residence in a minimum/mid-level service county or lack of employment exemptions at complete review.

A—1933.2.1 Personal Disability or Caring for a Family Member With a Disability

Revision 14-3; Effective July 1, 2014

TANF and TANF-SP

The advisor must:

- obtain a new Form H1836-A, Medical Release/Physician's Statement, or Form H1836-B, Medical Release/Physician's Statement, if the form in the EDG record is more than six months old to verify that the applicant:
  - or family member still has a disability expected to last more than 180 days, or
  - is needed in the home to provide care for a household member with a disability;
- verify that the caretaker or second parent with a disability is receiving HHSC Long-term Services and Supports or, in the case of a family member with a disability, that the recipient continues to be designated as the primary caregiver in the family member's care plan;

- verify that an application for SSI has been submitted since the previous TANF application, if applicable, or require a new application for SSI if it has now been 12 months since being denied for SSI; or
- verify that the caretaker/second parent or family member is certified for SSI.

Note: If the caretaker/second parent with a disability already receives SSI, then eligibility for the personal disability exemption is met. If the family member with a disability receives SSI, a current Form H1836-B is still required to verify that the caretaker/second parent is needed in the home to provide care.

At complete review, if the member with a disability ...	and ...	then ...
applied for SSI benefits,	the application is pending,	accept a pending notice as verification of the application or perform State Online Query/Wire Third-Party Query (SOLQ/WTPY) inquiry to check the status of the SSI application. **Note**: If the pending notice is more than 12 months old and the individual indicates this is the only notice received, check the status by performing SOLQ/WTPY inquiry.
applied for SSI benefits,	the individual is eligible for SSI benefits,	follow procedures in A-2344.1, Form TF0001 Required (Adequate Notice); send Form TF0001, Notice of Case Action, to remove the SSI household member from the EDG; and adjust the SNAP EDG, if applicable. **Note**: If an adult in a TANF-SP household is certified for SSI, transfer the remaining members to TANF, if eligible.
applied for SSI benefits,	the individual is ineligible for SSI benefits and provides Form H1836-A indicating the individual meets disability criteria,	accept Form H1836-A as verification.
has not applied for SSI benefits,		deny the EDG. If the individual reapplies after denial, the individual must provide verification of SSI application before certification.

A—1933.2.2 Family Violence

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

At complete review, if the recipient continues to indicate a victim of family violence status, provide the extended TANF recipient with Form H1713, Service Plan for Family Violence Option and Report of Good Cause. Make an assessment referral to the family violence program specialist following policy in A-1131.1, Good Cause for Family Violence Option. A list of Family Violence Shelters is located at www.hhsc.state.tx.us/Help/family-violence/centers.shtml. If the family violence specialist establishes that family violence continues to exist, the household continues to be eligible for this exemption.

A-1940, ABAWD Work Requirement

Body

Revision 25-4; Effective Oct. 1, 2025

SNAP

The ABAWD work requirement:

- applies the month after a person turns 18; and

- stops applying the month the person turns 55.

To meet the ABAWD work requirement means:

- working 20 hours per week averaging 80 hours a month;
- participating in and complying with the requirements of a work program 20 hours per week;
- any combination of working and participating in a work program for a total of 20 hours per week; or
- participating in and complying with a workfare program through the SNAP Employment and Training (E&T) program.

The first countable month of a person's 36-month federal time limit (FTL) is:

- the first month an ABAWD works less than an average of 20 hours per week; and
- receives SNAP benefits in Texas or any other state.

Note: A month where benefits are prorated is not a countable month.

A person not meeting the ABAWD work requirement is referred to participate in a workfare program through the SNAP E&T program. Once the Texas Workforce Commission (TWC) notification that the ABAWD is participating in SNAP E&T is received, stop counting months toward their ABAWD FTL effective the same month the person started participating. Remove any countable months from the eligibility determination system starting with the first month of participation and future months. Do not count a benefit month as one of the three initial ABAWD FTL months if the person participates in SNAP E&T.

If removal of ABAWD months causes the removal of the first countable month of the 36-month period, adjust the 36-month period. Start the new 36-month period with the first month the person does not meet the ABAWD work requirement. If all countable ABAWD FTL months are removed, the 36-month period must also be removed.

Note: The initial three months of time-limited benefits do not have to be consecutive.

A-1941 Definition of Work

Revision 24-3; Effective July 1, 2019

SNAP

Work may be:

- work in exchange for money (employment or self-employment);
- work in exchange for goods or services (in-kind work); or
- unpaid work with a business, government entity, or non-profit organization (volunteer labor).

Notes:

- Consider employment paid by vendor payment as regular employment.
- Consider work performed under the National and Community Services Act or Domestic Volunteer Service Act, such as AmeriCorps VISTA, as work to meet the work requirement.

A-1941.1 Meeting the Work Requirement Through Self-Employment

Revision 24-4; Effective Oct. 1, 2024

SNAP

Consider a person as meeting the ABAWD work requirement if their self-employment earnings are more than or equal to the federal minimum wage multiplied by 20 hours per week.

If the gross self-employment earnings do not equal at least 20 hours per week multiplied by the federal minimum wage, the person must verify that they are working an average of 20 hours a week. They do this by using the same verification procedures used for Employment and Training (E&T) exemptions.

Related Policy

ABAWD Exceptions, A-1942
Verification Sources, A-1970

A-1941.2 Meeting the Work Requirement Through a Work Program

Revision 23-4; Effective Oct. 1, 2023

SNAP

A person may participate in one of the following work programs at least 20 hours per week to meet the work requirement:

- Workforce Innovation and Opportunity Act (WIOA);
- Trade Adjustment Assistance Act Program;
- SNAP E&T Program. **Note**: E&T Workfare also meets this work requirement even if it is less than 20 hours per week; or
- an employment and training program for veterans operated by the U.S. Department of Labor (DOL) or the U.S. Department of Veteran's Affairs (VA).

Related Policy

Verification Requirements, A-1970

A-1942 ABAWD Exceptions

Revision 24-2; Effective April 1, 2024

SNAP

A person is exempt from the ABAWD work requirement if they:

- are pregnant;
- are a member of a SNAP EDG where a household member on the SNAP EDG is under 18;
- are exempt from E&T registration;
- live in a waiver area;
- live in a SNAP non-E&T county;
- meet the criteria as being physically or mentally unfit to work by qualifying for Code E as defined under the SNAP Work Requirement Exemption;
- are a veteran;
- are homeless; or
- are age 24 or younger and were in foster care under the responsibility of any state, district, territory, or Indian Tribal Organization on the date they turned 18.

Related Policy

SNAP Work Requirement Exemptions, A-1822.1
SNAP ABAWD Work Requirement Waiver Counties, C-330
SNAP Non-Employment and Training Counties, C-341

A-1950, Counting Months Toward Time-Limited Eligibility

Body

Revision 24-4; Effective Oct. 1, 2024

SNAP

Count a benefit month as one of the three ABAWD Federal Time Limit (FTL) months, if in that month the person:

- receives SNAP benefits in Texas or any other state;
- is not exempt from the work requirement; and
- fails to work or participate in a work program at least 80 hours in a 30-calendar day period.

Note: Staff must verify any benefits the person received in another state as an ABAWD if the recipient shows receiving benefits outside of Texas and the information is readily available.

ABAWD FTL months must also be applied retroactively when the person:

- was issued restored benefits;
- erroneously received an exemption from ABAWD work requirements and time limits; or
- correctly received an exemption from ABAWD work requirements and time limits, but the household situation changed and the ABAWD status was not updated.

Do not count SNAP benefit months toward the ABAWD FTL when HHSC or the out-of-state agency:

- disqualifies the person from SNAP for any reason;
- prorates benefits; or
- files an overpayment claim for the entire benefit month.

Redetermine eligibility effective the benefit month after the third countable time-limited benefit month. Staff may set a:

- special review before cutoff in the third countable month; or
- three-month certification if the 36-month period starts at certification.

Related Policy

Regaining Eligibility, A-1960

A-1951 After the Three Months of Time-Limited SNAP Eligibility

Revision 24-4; Effective Oct. 1, 2024

SNAP

When the initial three months of time-limited eligibility expire, staff must:

- disqualify the ABAWD; or
- deny the EDG if:
  - it is a single-person household; or
  - the disqualification makes the household ineligible.

Provide advance notice of adverse action, if required.

Note: Use the notice language specific to this disqualification in the comment section of Form TF0001, Notice of Case Action.

Related Policy

Second Time-Limited Three-Month SNAP Eligibility Period, A-1961

A-1960, Regaining Eligibility

Body

Revision 24-2; Effective April 1, 2024

SNAP

If not meeting the ABAWD work requirement, ABAWDs have a federal time limit (FTL) allowing three months of SNAP eligibility in a 36-month period. During their initial 36-month period, the person must meet the ABAWD work rules for at least 30 calendar days before regaining eligibility. After regaining eligibility during their initial 36-month period, the person is eligible for a second consecutive three-month period, if not meeting the ABAWD work requirement.

A person who loses eligibility due to the ABAWD federal time limit (FTL) may regain eligibility an unlimited number of times if the person becomes exempt from the ABAWD work requirement.

After the initial 36-month period ends, the person must meet the ABAWD work requirement for at least 30 consecutive calendar days before regaining a second 36-month period.

Related Policy

Definition of Work, A-1941
ABAWD Exceptions, A-1942
Counting Months Toward Time-Limited Eligibility, A-1950
After the Three Months of Time-Limited SNAP Eligibility, A-1951

A—1961 Second Time-Limited Three-Month SNAP Eligibility Period

Revision 20-3; Effective July 1, 2020

SNAP

A person who already received the three months of time-limited benefits can qualify for one additional three-month period of eligibility in the 36-month period if they are not meeting the work requirement but have worked for a specified period of time **after** receiving the three initial ABAWD FTL months. The person must:

- meet the 20-hour per week work requirement after the first three-month eligibility period by working at least 80 hours in a 30-day period; or
- participate in a recognized work program for at least 80 hours in a 30-day period after the first three-month eligibility period. A combination of work and participation in a specified work program also meets this requirement.

Note: The person does not have to receive SNAP benefits during the month they worked or participated in a work program for the minimum amount of hours to regain eligibility.

If HHSC prorates benefits, do not count the prorated month when determining the first month of the additional three-month period.

The person can receive the additional eligibility period once in the 36-month period. Limit the additional eligibility period to three consecutive months, even if the person returns to work or if HHSC denies SNAP for another reason during the three-month period. The additional consecutive three-month period may extend past the end of the original 36-month period if it begins during the original 36-month period.

For example: Brad Johnson's original 36-month period is September 2016 to August 2019. Brad used his initial three months in September 2016, October 2016 and April 2017. He reapplied for benefits on July 3, 2019, and met the criteria for an additional three-month period. Brad's second three-month period is August 2019, September 2019 and October 2019. Because July 2019 benefits are prorated, July is not a countable month. A new 36-month period can begin November 2019.

If all certified members' additional three-month eligibility periods ...	then ...
expire in the same month,	set the certification period to end the last month of the three-month eligibility period.
do not expire in the same month,	set special reviews to deny each member effective the end of the third month of the additional eligibility period.

Exception: ABAWDs in Texas are assigned to participate in workfare through SNAP E&T. When notification is received from TWC that the ABAWD met work requirements by participating in SNAP E&T in the first month of the second three-month segment, remove the second three-month segment. If the ABAWD begins participating in SNAP E&T in the second or third month of the second three-month segment, the three consecutive ABAWD FTL months must remain.

Additionally, when the modification of the ABAWD FTL months results in the first countable month of the second three-month segment being removed, the second three-month segment must be adjusted to start with the first countable month in which the ABAWD does not meet the work requirements. If the first countable month of the second three-month segment is removed, the consecutive months of the second three-month segment must also be removed.

For Example: Brad used his initial three months in September 2016, October 2016 and April 2017. Brad regains eligibility and his second three-month period is August 2018, September 2018 and October 2018. In January 2019, Brad files a new application and it is discovered that he was meeting the work requirement through participating in Workfare with TWC in August 2018 and ongoing. Staff would remove August 2018 as a countable month, and by doing so, removes the second three-month segment of consecutive months.

Related Policy

Meeting the Work Requirement Through a Work Program, A-1941.2

A-1970, Verification Requirements

Body

Revision 24-4; Effective Oct. 1, 2024

TANF

Verify:

- any out-of-state TANF benefits received on or after October 1999;
- any hardship exemption for TANF per Hardship Exemptions policy; and
- the hardship exemption at each complete review after certification for extended TANF based on personal disability, caring for a family member with a disability, or family violence.

Related Policy

Hardship Exemptions, A-1933
Advisor Action at Application, A-1933.1
Advisor Action at Complete Review, A-1933.2

SNAP

Verify if an ABAWD:

- meets the ABAWD work requirement by:
  - working or volunteering for at least 80 hours in a 30-calendar day period; or
  - participating at least 20 hours per week in:
    - a Workforce Innovation and Opportunity Act (WIOA) funded activity through the local WIOA program administrative office;
    - a Trade Adjustment Assistance (TAA) program through a Local Workforce Development Board (LWDB);
    - a SNAP Employment & Training (E&T) program through the local E&T office. **Note**: E&T Workfare also meets this work requirement even if it is less than 20 hours per week; or
    - an E&T program for veterans operated by the U.S. Department of Labor (DOL) or the U.S. Department of Veterans Affairs (VA);
- meets an ABAWD work requirement exception criteria because the person:
  - is pregnant; or
  - meets the criteria as being physically or mentally unfit to work by qualifying for SNAP work requirement exemption Code E; or
- received benefits in another state during any month countable toward their ABAWD FTL.

If questionable, verify if an ABAWD:

- has a business or non-profit organization;
- is a member of a SNAP EDG where a household member is under 18;
- is a veteran;
- is homeless; or
- is 24 or younger and was in foster care under the responsibility of any state, district, territory, or Indian Tribal Organization on the date they turned 18.

When determining if a person qualifies to regain eligibility for SNAP after the person has used three countable months of benefits in a 36-month period, verify that the person worked, or participated in a work program, for at least 80 hours in a consecutive 30-calendar day period.

Verify any benefits ABAWD household members received in another state, if the household shows receiving benefits outside of Texas.

Related Policy

SNAP Work Requirement Exemptions, A-1822.1
ABAWD Exceptions, A-1942
Counting Months Toward Time Limited Eligibility, A-1950

A-1971 Verification Sources

Revision 24-4; Effective Oct. 1, 2024

TANF

Use the TANF Agencies website to contact other state agencies to verify the number of benefit months previously received by the household.

SNAP

Use income verification source policy when an ABAWD has earned income or self-employment income to verify if the ABAWD meets the ABAWD work requirement.

Use Form H1822, ABAWD E&T Work Requirement Verification (PDF), to verify participation in the following work programs:

- WIOA through the local WIOA program administrative office;

- Trade Adjustment Assistance Program through a LWDB;
- SNAP E&T program through the local E&T office; or
- an E&T program for veterans operated by the DOL or the VA.

Use Form H3037, Report of Pregnancy (PDF), or other documentation containing the same information as Form H3037 to verify a person is exempt from the ABAWD work requirement because they are pregnant. Verification of pregnancy must be from an acceptable source such as a physician, hospital, family planning agency or social service agency.

Use Form H1836-A, Medical Release/Physician's Statement (PDF), to verify a person is physically or mentally unfit to work. A new Form H1836-A must be obtained when the form is more than 12 months old. If the Form H1836-A verifies a person is physically or mentally unfit to work, then they meet the ABAWD exception criteria and are also considered exempt from the E&T work requirement.

Use the National Directory of SNAP Agencies on The LOOP to verify any countable months of benefits received in another state.

If an ABAWD exception is questionable, use any reasonable verification, such as:

- federal income tax documents or nonprofit certification documents from the Internal Revenue Service or the Texas State Comptroller of Public Accounts;
- a collateral contact with a homeless shelter, person they are staying with, or any other person aware of the household's circumstances;
- service department records, such as a DD Form 214, Certificate of Release or Discharge from Active Duty, original Certificate of Discharge, Report of Transfer or Discharge, military ID card showing service in the armed forces;
- correspondence or contact from the Department of Veteran Affairs including benefit payment or award letter;
- VA ID Card showing service in the armed forces;
- driver's license indicating veteran status; or
- data sharing or collateral contact from other social service workers or foster care agencies.

Related Policy

New Texas Residents, A-720
Verification Sources, A-1371
SNAP Work Requirement Exemptions, A-1822.1
Claiming Exemption Due to Disability of Self, A-1822.1.1

A-1980, Documentation Requirements

Body

Revision 25-4; Effective Oct. 1, 2025

TANF

Document:

- the household was informed of Federal Time Limits (FTLs) at application, periodic review or when adding a new caretaker or second parent to the household; and
- any out-of-state TANF benefits received on or after October 1999.

SNAP

Document:

- the exception criteria for each person 18 through 54;
- the number of countable FTL months received in another state and how that information was verified;
- any time the person's 36-month time-limited period begins;
  - the first and last month of the person's 36-month period; and
  - months HHSC or any other state issues or requests a SNAP benefit that counts toward the person's three months of time-limited benefits; and
- when the initial three months of time-limited eligibility expires.

Related Policy

The Texas Works Documentation Guide

A-2000 Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation

A-2010, General Policy

Body

Revision 14-2; Effective April 1, 2014

All Programs

Staff must use available technology to verify identity and prevent duplicate participation.

Related Policy

Identity, A-600
Duplicate Participation, B-421.1
Duplicate Participation Procedures, B-454.1
Claims, B-700
Referrals for Intentional Program Violation (IPV), B-900
Establishing Identity for Contact Outside the Interview Process, B-1213

A-2020, Authenticating a Caller

Body

Revision 26-2; Effective April 1, 2026

All Programs

Staff must authenticate a caller during any phone contact with the household.

Staff must ask identifying questions to confirm the identity of the caller.

Staff should explain that the authentication questions help ensure the caller's identity and protect their confidentiality and information. Do this at the start of the call.

A-2020.1 Authentication Questions and Verification Sources

Revision 26-2; Effective April 1, 2026

All Programs

Staff must authenticate a caller during any phone contact with the household.

Ask client-related questions to authenticate a caller's identity. These are questions that the person, authorized representative (AR), or personal representative (PR) will usually know the answers to but are not easily known to others.

Use available verification sources to select the questions and verify the responses. These sources include but are not limited to:

- Texas Integrated Eligibility Redesign System (TIERS);
- Data Broker; and
- Birth Verification System (BVS).

Not all the questions are applicable to every household. Staff should use prudent person principle to determine if enough questions apply to the household's situation and if the person provides accurate responses.

The person must respond accurately to two questions from the lists below. Ask as many head of household-related questions as needed to allow the person to provide two accurate responses.

Initially, questions with available verifications should be chosen from a source other than the application, such as:

- What is your Texas driver license or Texas state identification number?
- What was a previous address for any place you lived?
- Who are your neighbors?
- What is the date of your wedding anniversary?
- When was your divorce final?

If the person cannot provide two correct answers to the above questions, ask as many of these other questions as needed to receive a total of two accurate responses:

- What is the date of birth for a child on your case?
- What type of vehicle do you or another household member own?
- Who are the members of your household?
- What types of income do you or a member of your household receive?
- From whom do you receive child support?
- What is your alien registration number?
- What is your or your spouse's maiden name?
- What is the name of a bank or financial institution where you have an account?
- What is the name of a previous or last employer for you or another household member?
- What is the name of your mortgage company or landlord?
- To whom do you pay child support?

If necessary, request a credit report on the head of household:

- for applicants new to Texas;
- when none of the above questions apply to the household's situation; or
- when you cannot gather verification of the responses from the sources listed above.

Information from the head of household's credit report may be used to develop questions to authenticate the caller. Examples of credit report questions to authenticate the caller include:

- What is the name of a gas station or department store where you have a credit card?
- What is the name of a major credit card you have, such as a Visa, MasterCard, American Express or Discover?
- What is the name of the bank or financial institution which holds your student loan?
- What is the name of the bank or financial institution which holds your car loan?

Related Policy

Prudent Person Principle, A-137
Actions on Inaccurate Responses to the Questions, A-2020.3
Documentation Requirements, A-2050
Establishing Identity for Contact Outside the Interview Process, B-1213
Telephone Contact, B-1213.1

A-2020.2 Actions When Unable to Authenticate the Caller

Revision 26-2; Effective April 1, 2026

All Programs

Staff should submit a policy clearance request to field policy staff if:

- none of the questions apply to a particular case situation; or
- responses cannot be verified.

A-2020.3 Actions on Inaccurate Responses to the Questions

Revision 26-2; Effective April 1, 2026

All Programs

If enough questions are applicable to the case but the caller cannot provide correct responses to any two questions to authenticate their identity advise them that:

- the interview will be completed to gather required information; and
- the person must come to the local office and provide verification of their identity in person.

Staff must document if the person did not correctly respond to the authentication questions in the case record.

Send the household Form H1020, Request for Information or Action, requesting that the caller provide proof of identity at an HHSC local office.

Do not deny an active Eligibility Determination Group (EDG) when adding a program if the caller fails to come to an HHSC local office to authenticate their identity.

Related Policy

Pending Information, A-135
Expedited Service, A-140
Pending Verification on Applications, B-115
Processing Redeterminations, B-122

A-2020.4 Claiming Hardship for Coming to the Office

Revision 26-2; Effective April 1, 2026

All Programs

If the caller states they cannot come to an HHSC local office, allow the caller to claim hardship for any of the following reasons:

- residence is more than 30 miles from an HHSC local office, even if an itinerant office is less than 30 miles from the caller's' home;
- work or training schedule;
- transportation difficulties;
- prolonged severe weather;
- illness;
- care of a household member, who does not have to be part of the certified household; or
- victims of family violence.

The person must provide authentication of their identity by:

- mail;
- uploading information to their Your Texas Benefits account; or
- fax.

A-2020.5 Actions When Verification Is Provided at the Local Office

Revision 26-2; Effective April 1, 2026

All Programs

Staff documents if the caller was authenticated in the case record and what information was provided if the caller comes to an HHSC local office and provides appropriate authentication.

A-2020.6 Denial for Failure to Authenticate Identity

Revision 26-2; Effective April 1, 2026

All Programs

The eligibility determination system creates a task to deny only the EDG that authentication questions were asked for if the caller does not come to the local office to provide acceptable verification of identity by the final due date on Form H1020, Request for Information or Action. This is done by using the denial reason: failure to provide required information within specified time frame.

Related Policy

Pending Information, A-135
Pending Verification on Applications, B-115
Processing Redeterminations, B-122

A-2030, Prevention of Duplicate Participation

Body

Revision 24-4; Effective Oct. 1, 2024

All Programs

At application and when adding a new household member, verify that household members do not currently receive TANF, Medicaid or SNAP benefits.

Related Policy

Duplicate Participation, B-421.1
Effective Date Requirements, B-640

A-2030.1 Inquiry and Sources

Revision 15-4; Effective October 1, 2015

All Programs

HHSC staff must use existing technology, such as TIERS, Data Broker, State Online Query (SOLQ), etc., to verify the household members do not receive duplicate benefits.

At application, staff must:

- perform a TIERS file clearance to identify any household members receiving benefits in TANF, Medicaid or SNAP;
- use available online sources to verify the validity of information provided by the individual and missing or questionable information;
- contact the household and allow the individual the opportunity to explain any discrepancy; and/or
- send the household Form H1020, Request for Information or Action, requesting information or proof to resolve the discrepancies, if necessary.

Related Policy

Registering an Application, A-122.3
Automated Support Systems, C-800

A-2030.2 Duplicate Participation Match Procedures

Revision 15-4; Effective October 1, 2015

All Programs

If a household member is currently active for the same program on another EDG, HHSC staff must:

- notify the corresponding HHSC office by email or telephone;
- determine the correct EDG/case that will remain open;
- deny TANF, Medicaid and SNAP, if needed to prevent duplicate participation; and
- refer the household to the Office of Inspector General (OIG) for a TANF and/or SNAP overpayment.

Staff should refer to B-771, Filing an Overpayment Referral Using Automated System for the Office of Inspector General (ASOIG), and B-772, Filing an Overpayment Referral Using TIERS, for instructions on submitting a fraud and/or non-fraud referral to OIG. Staff may use either the TIERS interface with ASOIG or initiate the fraud referral directly in ASOIG.

Related Policy

Duplicate Participation, B-421.1
Participation Twice in Same Month, B-454
Duplicate Participation Procedures, B-454.1
Claims, B-700
Referrals for Intentional Program Violation (IPV), B-900

A-2040, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

All Programs

TIERS file clearance and any other available sources may be used to verify the identity of the person being interviewed and that the household does not receive duplicate benefits.

Related Policy

Verification Sources, A-621
Questionable Information, C-920
Providing Verification, C-930

A-2040.1 Authentication of Caller Identity Verification Sources

Revision 26-2; Effective April 1, 2026

All Programs

Authenticate a caller's identity using the following verification sources:

- Adoption papers or records
- Birth certificate
- Certificate of Naturalization
- Certificate of U.S. citizenship
- Collateral statement from a non-relative
- Department of Public Safety (DPS) current or expired identification card
- Driver license
- Finding of citizenship by another federal or state agency
- Hospital or birth records
- Identification card issued by federal, state, or local government
- Immigration documents
- Military dependent's identification card with photo or other identifying information
- School identification card
- Tribal enrollment card
- U.S. Coast Guard Merchant Mariner card with photo or other identifying info
- U.S. passport
- U.S. military card or draft record with photo or other identifying information
- Voter registration card
- Wage or check stub or check
- Work identification

A-2050, Documentation Requirements

Body

Revision 26-2; Effective April 1, 2026

All Programs

Document how the caller was authenticated in the case record.

Staff must document the following in the case record:

- if the caller was or was not verified;
- a brief statement showing which questions were answered correctly, such as saying, caller verified Texas driver license and name of mortgage company;
- if the caller fails to correctly answer the questions, note which questions were asked and the incorrect responses given;
- if the caller came into the office and provided verification of identity or claimed hardship; and
- if an OIG referral was made via ASOIG; otherwise use the eligibility determination system functionality.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

A-2100, Personal Responsibility Agreement

A-2110, General Policy

Body

Revision 19-3; Effective July 1, 2019

TANF

Require Temporary Assistance for Needy Families (TANF) recipients who are caretakers or second parents to sign Form H1073, Personal Responsibility Agreement (PRA). This includes minor parents who are certified as an adult. The agreement requires the adult caretaker and second parent to:

- participate in the Choices program (unless exempt);
- cooperate with child support requirements;
- not voluntarily quit a job;
- have their child(ren) screened through the Texas Health Steps program;
- have their child(ren) immunized, unless exempt;
- have their child(ren) attend school;
- attend parenting skills training if referred; and
- not abuse drugs or alcohol.

Require TANF payees and disqualified adults to sign Form H1073. The PRA requires the payee or disqualified adult to:

- cooperate with child support requirements;
- have child(ren) screened through the Texas Health Steps program;
- have child(ren) immunized, unless exempt;
- have child(ren) attend school; and
- not abuse drugs or alcohol.

If a caretaker, second parent, payee, or disqualified adult fails to sign Form H1073, deny the application. Failure to cooperate with the PRA results in a full-family sanction for the TANF household.

A payee certified as a caretaker on a separate TANF EDG may sign one PRA that is applicable to both EDGs.

A-2120, Individual Responsibilities

Body

Revision 12-3; Effective July 1, 2012

TANF

Apply the following policies of the PRA, as appropriate, to caretakers, second parents, certified children, payees, and disqualified adults.

A–2121 Choices

Revision 12-3; Effective July 1, 2012

A–2121.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform the caretaker and second parents about the Choices requirements and full-family sanctions for noncooperation with Choices if they are required to register. Use TANF policies and procedures in A-1800, Employment Services, for a caretaker and second parent who sign Form H1073, Personal Responsibility Agreement.

Related Policy

Noncooperation with Choices, A-1843
TANF-SP Procedures, A-1843.1
Action on Noncooperation, A-1845
Completing the Penalty Action, A-1845.2
Re-establishing Eligibility During the Penalty Period, A-1847
Determining Good Cause, A-1860

A–2121.2 Ending a Choices Penalty

Revision 12-3; Effective July 1, 2012

TANF

Complete or Incomplete Review — The penalty end date is the month of cooperation.

Related Policy
Ending an Open Penalty, A-2145

A–2122 Child Support

Revision 05-3; Effective July 1, 2005

A–2122.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform the caretaker, second parent, payee and disqualified adult of the child support requirements and the full-family sanction. Use current TANF policies and procedures found in A-1100, Child Support, for individuals who are required to sign Form H1073, Personal Responsibility Agreement.

Related Policy
TANF, A-1124
Counting Child Support, A-1326.2.1
Imposing a Penalty, A-2144
Ending an Open Penalty, A-2145

A–2122.2 Explanation of Child/Medical Support, Family Violence and Good Cause

Revision 12-3; Effective July 1, 2012

TANF

In addition to signing Form H1010, which constitutes the assignment of rights to child/medical support, the individual must also sign Form H1073, Personal Responsibility Agreement. Use Form H1712, Explanation of Child/Medical Support, Family Violence and Good Cause, to help the individual understand the child support requirements.

A–2122.3 Good Cause for Child Support Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Determine if the individual has good cause for not cooperating with child support requirements using TANF policy in A-1130, Explanation of Good Cause. If the individual has good cause, do not sanction the household.

A–2122.4 Starting a Child Support Penalty

Revision 12-3; Effective July 1, 2012

TANF

Use the following chart to determine when to start a penalty.

If the individual fails to cooperate with the child support requirements at ...	then ...
application, complete review, or incomplete review,	refer to A-2144, Imposing a Penalty.
reapplication,	**if the individual has ...** / **then ...**
-	no open penalty, / follow procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reappplication.

If the individual fails to cooperate with the child support requirements at ...	then ...	
-	an open penalty,	follow procedures in A-2152,Second Noncooperation During Pay For Performance.

Note: A child support noncooperation is not applicable if the noncooperation occurred:

- before Sept. 1, 2003, and the full-family sanction was never imposed; or
- on or after Sept. 1, 2003, but before signing Form H1073. Advisors must not open new PRA penalties for noncooperations that occurred before they signed the PRA.

A–2122.5 Ending a Child Support Penalty

Revision 12-3; Effective July 1, 2012

TANF

If the individual cures his penalty or proves good cause, end the penalty following procedures in A-2145, Ending an Open Penalty. **Note:** If the individual reports cooperation with the Office of Attorney General (OAG) but the advisor has not received Form H1701, contact the child support officer for the date of cooperation.

A–2123 Voluntary Quit

Revision 12-3; Effective July 1, 2012

A–2123.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform the caretaker and/or second parent (including a minor parent who is a caretaker or second parent) that they must not voluntarily quit a job of 30 or more hours a week. Voluntary quit applies to a caretaker/second parent who:

- signed the responsibility agreement;
- is non-exempt from Choices requirements whether the individual lives in a full service Choices county or a minimum service Choices county; and
- quit a job that was 30 hours or more a week without good cause.

A person has voluntarily quit a job if the individual:

- lost a job because of participation in a strike; or
- left a job unannounced or does not return to work without good cause, even if the person was technically fired.

A person is not considered to have voluntarily quit a job if the individual:

- reduced hours of employment, but continues to work for the same employer;
- ends a self-employment enterprise;
- resigns a job at the employer's demand;
- is currently on strike; or
- has good cause.

Note: See A-1850 for Supplemental Nutrition Assistance Program (SNAP) Voluntary Quit policy.

A–2123.2 Failure to Cooperate with Voluntary Quit

Revision 12-3; Effective July 1, 2012

TANF

Determine whether the individual failed to cooperate at application, complete or incomplete review after signing Form H1073. If the individual voluntarily quit a job before signing Form H1073, voluntary quit does not apply.

See Advisor Action on Noncooperation in A-2123.5.

A–2123.3 Curing Voluntary Quit

Revision 05-3; Effective July 1, 2005

TANF

The individual may cure the voluntary quit penalty if the individual:

- obtains a job working 30 hours or more a week; or
- becomes exempt from Choices.

A–2123.4 Good Cause for Voluntary Quit Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Good cause exists when circumstances beyond the recipient's control prevent the person from cooperating with the requirements. Explore all reasons for good cause before establishing voluntary quit. Reasons for good cause are the same as the SNAP Reasons for Good Cause in A-1861 with the following exception.

Exception: Acceptance of a job that later does not materialize or results in employment of less than 30 hours a week or weekly earnings of less than federal minimum wage multiplied by 30 hours is not considered good cause.

A–2123.5 Advisor Action on Noncooperation

Revision 05-3; Effective July 1, 2005

TANF

Apply a full-family sanction until the individual cooperates.

A–2123.5.1 Starting a Voluntary Quit Penalty

Revision 12-3; Effective July 1, 2012

TANF

Use the following chart to determine when to start a penalty.

If the advisor determines an individual voluntarily quit a job at...	then ...	
initial application,	start the full-family sanction the month of noncooperation if the individual signed Form H1073 before voluntarily quitting a job.	
complete or incomplete review,	refer to A-2144, Imposing a Penalty.	
reapplication,	**if the individual has ...**	**then ...**
-	no open voluntarily quit penalty,	follow procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reappplication.
-	an open penalty,	follow procedures in A-2152, Second Noncooperation During Pay For Performance.

A–2124 Texas Health Steps Program

Revision 19-3; Effective July 1, 2019

A–2124.1 When the Person Signs Form H1073

Revision 19-3; Effective July 1, 2019

TANF

Inform a caretaker, second parent, payee, or disqualified adult who receives TANF for a child age two through 18 that the child must have:

- a Texas Health Steps medical checkup per the Texas Health Steps schedule; or
- good cause for not having the Texas Health Steps medical checkup.

Provide the caretaker, second parent, payee, or disqualified adult with the Texas Health Steps schedule (Texas Health Steps "Checkups Help Children Stay Healthy!") for medical checkups and additional information provided by Texas Health Steps Outreach and Informing staff.

Related Policy
Texas Health Steps, A-1531

A–2124.1.1 Setting the Texas Health Steps Overdue Month

Revision 19-3; Effective July 1, 2019

TANF

TIERS calculates and sets an overdue month for applications and complete reviews. TIERS uses the Texas Health Steps medical schedule and the child's birthdate plus 12 months to determine the overdue month. The child's birth month is month zero. The overdue month begins the first calendar day of the 12th month. This is the same formula Texas Health Steps uses to determine the child's overdue month for a medical checkup.

Example: The household has a child who turns 6 on April 3. According to the Texas Health Steps schedule, the child is due for a checkup when the child turns age 6. Consider April as month zero, and add 12 months to determine the overdue month. In this example, if the child does not have a medical checkup by the end of March, the child is overdue beginning April 1.

A–2124.2 At the First Complete Review After the Caretaker or Second Parent Signs Form H1073

Revision 19-3; Effective July 1, 2019

TANF

Determine if the person failed to comply at each complete review after the person signs Form H1073. If the overdue month is before or in the complete review interview month, the child is overdue. After the interview month and you complete the EDG in the:

- interview month, the child is not overdue; or
- overdue month, the child is overdue and must be penalized if the child has not had a Texas Health Steps medical checkup. At the interview, refer the household to the Texas Health Steps worker for assistance.

Related Policy

Staff Action if the Overdue Month Is Before or In the Complete Review Interview Month, A-2124.3

A–2124.2.1 Determining if the Child had a Texas Health Steps Medical Checkup

Revision 19-3; Effective July 1, 2019

TANF

Determine if a child had a Texas Health Steps medical checkup using one of the following methods:

- checking information in TIERS Data Collection;
- verifying the checkup using Form H1087, Verification of Texas Health Steps Checkup; or
- verifying and accepting a doctor's written statement if it:
  - is provided with the application or at the interview; and
  - provides enough information to determine a Texas Health Steps checkup has been completed.

Note:

- Do not pend for a doctor's statement.
- Follow the chart in A-2124.3, Staff Action if the Overdue Month is Before or In the Complete Review Interview Month, if the person states the child has had a checkup but does not have verification at the time of the interview.

A–2124.3 Staff Action if the Overdue Month Is Before or In the Complete Review Interview Month

Revision 19-3; Effective July 1, 2019

TANF

Determine if the child had a medical checkup and use the following chart to determine the action to take.

If at the complete review the checkup is ...	then ...
not overdue,	do not apply a penalty.
overdue, but proof of a medical checkup that occurred before the discovery date is provided,	update the Texas Health Steps screening date in TIERS Data Collection.
overdue and the parent or guardian states the child had a checkup before the discovery date, but does not have proof,	fax Form H1087, Verification of Texas Health Steps Checkup, to Texas Health Steps staff at 512-533-3867. Do not refer the person to the Medicaid provider. Local Texas Health Steps staff will contact the Medicaid provider. Pend the EDG to receive proof from Texas Health Steps staff. If proof is received within 10 days, update the Texas Health Steps screening date in TIERS Data Collection. TIERS recalculates a new overdue month. **Note:** If proof is not received within 10 days, contact Toni Sanders at 512-919-1601 If Texas Health Steps informs staff that they need more than 10 days, allow an additional 10 days. If staff determine the additional 10 days may cause a delinquency, accept the person's statement that the child had a checkup and document in case comments. If Texas Health Steps provides proof of a checkup, take no further action. If Texas Health Steps states that a checkup did not occur, send Form TF0001, Notice of Case Action, advising the person of the sanction for noncooperation. **Note:** The Texas Health Steps checkup date must be before the discovery date. If the person has good cause for not complying, select the good cause reason. Refer to A-2124.5, Good Cause for Texas Health Steps Noncooperation.
overdue and the person states the TANF child has not had a checkup and that the person needs assistance making an appointment,	• Refer the person to Texas Health Steps staff using Form H1093, Texas Health Steps Extra Effort Referral. • If the person has good cause for not complying, select the good cause reason. Refer to A-2124.5, Good Cause for Texas Health Steps Noncooperation. • Apply a penalty for each child out of compliance without good cause. Refer to A-2124.6, Starting a Texas Health Steps Penalty.

A–2124.4 Texas Health Steps Overdue Month at Application

Revision 19-3; Effective July 1, 2019

TANF

For applications received in the last benefit month or in the two months following the last benefit month, determine if the child was not cooperating with the Texas Health Steps requirement in the last benefit month.

If the overdue month is:

- Before or in the last benefit month and a noncooperation has not been imposed, impose a full-family sanction.
- After the last benefit month, do not impose a full-family sanction.

Related Policy
Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1

A–2124.5 Good Cause for Texas Health Steps Noncooperation

Revision 19-3; Effective July 1, 2019

TANF

When a person fails to cooperate with the Texas Health Steps requirement, explore good cause before applying a penalty. The person may claim good cause for the following reasons:

- **Medical** — A screening puts the child's health at risk. The person may provide medical records, a certificate, affidavit or statement from a licensed physician that the screening would be injurious to the health of the child. If verification from a Texas Health Steps worker indicates the child has had a screening within 12 months before the overdue date, allow a medical good cause. The Texas Health Steps worker will work with the provider to get the child back on schedule.
- **Religion** — The family has a religious belief that does not allow the child to have a screening. The applicant may provide a verbal statement on behalf of the child stating that the screening conflicts with the practices of a recognized church or religious organization to which the family adheres.
- **No medical provider or transportation** — There is no medical provider or transportation available within the geographic area. Regional Texas Health Steps staff provide this information to regional staff on a quarterly basis.

The person must provide proof for good cause. If staff determine the person has good cause for not cooperating with the Texas Health Steps requirements, select the good cause reason in TIERS Data Collection.

Use the following chart to determine when to start good cause.

If staff determine that good cause exists at ...	and the person has ...	then ...
a complete review,	no open penalty,	start good cause the month the person provides proof.
a complete review,	an open penalty,	start good cause the month after the person provides proof. End the penalty the month the person provides proof.
reapplication,	no open penalty,	start good cause the month of reapplication.
reapplication,	an open penalty,	start good cause the month of reapplication. End the penalty the month before the reapplication month. **Exception:** End the penalty the month of reapplication if the person reapplies in a month in which benefits were received.

Redetermine good cause at the next complete review. The good cause end date is the month staff determine the person no longer has good cause.

A–2124.6 Starting a Texas Health Steps Penalty

Revision 19-3; Effective July 1, 2019

TANF

Failure to comply with the Texas Health Steps schedule results in a full-family sanction.

Use the following chart to determine when to impose a full-family sanction.

If the person fails to cooperate with the Texas Health Steps requirements at ...	then ...
complete review,	refer to A-2144, Imposing a Penalty.
reapplication,	if the person: • has an open penalty, follow procedures in A-2152, Second Noncooperation During Pay For Performance. • does not have an open penalty, See A-2131.2.1, Verifying Prior Cooperation Status at TANF Reapplication.

A–2124.7 Ending a Texas Health Steps Penalty

Revision 19-3; Effective July 1, 2019

TANF

At complete or incomplete reviews, end the penalty following procedures in A-2145, Ending an Open Penalty, if the person cooperates with the Texas Health Steps requirements or provides proof of good cause.

A–2125 Immunizations

Revision 12-3; Effective July 1, 2012

A–2125.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform caretakers, second parents, payees and disqualified adults who receive benefits for a child certified for TANF they must provide:

- proof that the child's immunizations are current; or
- good cause for not immunizing the child.

See Form H1012, Immunization Record, for the immunization schedule.

Related Policy

Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1

A–2125.2 Determining if Immunizations are Current

Revision 19-3; Effective July 1, 2019

TANF

To determine whether a child is current with immunizations, use:

- Form H1012, Immunization Record;
- verification that Texas Health Steps checkups are current for a child age 2 or older unless other information indicates the child is not up-to-date with the child's immunizations; or
- verification that a child is enrolled and attending school unless other information indicates the child is not up-to-date with the child's immunizations.

If the records are not current but the person provides proof that the child is on an alternate schedule, refer to A-2125.4 Good Cause for Immunizations Noncooperation, to allow good cause.

Do not count an immunization administered at birth as a required visit. An immunization is considered administered at birth if it is given between birth and seven days.

A–2125.3 Failure to Cooperate with Immunizations

Revision 12-3; Effective July 1, 2012

TANF

After the caretaker, second parent, payee or disqualified adult signs Form H1073, determine if the household cooperated with immunization requirements at each complete review.

Related Policy

Advisor Action on Noncooperation, A-2125.5
Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1

A–2125.4 Good Cause for Immunizations Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Individuals have good cause for not cooperating with the immunization requirement if the caretaker, second parent, payee or disqualified adult can prove that:

- immunizations are not in the child's best medical interest; or
- the individual declined immunizations for the child for reasons of conscience, including a religious belief.

Good cause exists in the following situations:

- **Medical** — Administering immunizations puts the child's health at risk. The individual may provide medical records, a certificate, affidavit, or a statement from a licensed physician that the required immunization poses a significant risk to the health of the child.
- **Conscientious Objector** — The immunization is being declined for reasons of conscience, including a religious belief. The person claiming the exemption must complete an affidavit on a form provided by DSHS stating the reason for the exemption. The child's parent, managing conservator, or guardian must sign the affidavit and have it notarized.
- **Alternate Schedule** — The child is behind on the current series of immunizations and the child is on an alternate schedule established by a doctor or health practitioner. The individual may provide a doctor's statement that the child is on an alternate schedule. Document the schedule and check the status at the next complete review.

Allow the individual 10 days to provide proof. Begin good cause the month the individual provides proof.

A–2125.5 Advisor Action on Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Apply a full-family sanction if a child does not meet the immunization requirement, and the household fails to provide proof of good cause.

Follow adverse action procedures in A-2343.1.

A–2125.5.1 Starting an Immunization Penalty

Revision 12-3; Effective January 1, 2012

TANF

Use the following chart to determine when to apply a full-family sanction when an individual noncooperates with immunizations.

If the individual fails to cooperate with the immunization requirements at ...	then ...
complete review,	refer to A-2144, Imposing a Penalty.
reapplication,	if the individual • has an open penalty, follow procedures in A-2152, Second Noncooperation During Pay For Performance. • does not have an open penalty, follow procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reapplication.

A–2125.5.2 Ending an Immunization Penalty

Revision 12-3; Effective July 1, 2012

TANF

At complete or incomplete Reviews, end the penalty the month the individual provides proof of cooperation with the immunization requirement or provides good cause following procedures in A-2145, Ending an Open Penalty.

A–2126 School Attendance

Revision 12-3; Effective July 1, 2012

A–2126.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform a caretaker, second parent, payee, disqualified adult or disqualified teen parent about the school attendance eligibility requirements in A-1610.

Related Policy
School Attendance, A-1600
Initial Application, A-2131.1
Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1
Imposing a Penalty, A-2144
Ending an Open Penalty, A-2145
Open Penalty at Reapplication, A-2151

A–2127 Parenting Skills Training

Revision 12-3; Effective July 1, 2012

A–2127.1 When the Individual Signs Form H1073

Revision 14-3; Effective July 1, 2014

TANF

Inform TANF household members they must attend parenting skills training if they meet either of the following parenting skills mandatory referral criteria:

- There is a caretaker, or a caretaker and a second parent, when the EDG includes a certified child under age 5; or
- A minor parent is certified as a child.

Note: A household member who does not meet the mandatory referral criteria may volunteer for parenting skills training. Discuss the training with an individual who expresses a need or interest.

A–2127.2 Actions and Time Frames

Revision 06-2; Effective April 1, 2006

TANF

When explaining the PRA requirements at application, inform household members they must attend parenting skills training if referred.

At application or when a household member's status changes so that the member now meets the referral criteria, refer household members to parenting skills training if they:

- meet the mandatory referral criteria; or
- volunteer.

At the first review after referral, the complete review after approving good cause or imposing a penalty, an incomplete review after the individual notifies you of training completion and at reapplication after referral, follow procedures in A-2127.4, A-2127.5 and A-2127.6.

A–2127.3 Referral

Revision 17-3; Effective July 1, 2017

TANF

Do not refer a person to parenting skills training if the TIERS “Individual Summary TANF Time Limits” page and the personal responsibility agreement indicate they have completed training. The “Parenting Skills” field will show Yes.

An individual must complete parenting skills training once. Acceptable verification of training completion includes training that occurred before the individual referral, such as in a high school curriculum. The following is what needs to be provided when referring a person to parenting skills training.

- Form H1088, Verification of Parenting Skills Training, for each person referred.

- Information from 211Texas.org on classes in the area that are available where they may complete the parenting skills class and obtain verification. To find a class:
  - Go to 211Texas.org.
  - Enter the family's zip code to search.
  - On the next page, select the word search function.
  - Enter "parenting skills classes" within the Advance Search text box.
- If the parenting skills classes in the area do not contain all of the following four components, provide the individual with information on the classes that contain the component(s) the individual and advisor determine would most benefit the individual:
  - nutrition education;
  - budgeting;
  - survival skills; and
  - instruction on the necessity of physical and emotional safety for children.
- instruction that a parenting skills training certificate, letter, Women, Infants and Children identification card (only one card is needed to satisfy verification requirements for two-parent families), or other documentation that verifies completion of training is acceptable proof.
- the name(s) of the referred member(s) on Form TF0001, Notice of Case Action; and
- the following additional information on Form TF0001 for individuals who meet the mandatory referral criteria:
  - attendance of a parenting skills training must occur before the family's next TANF periodic review; and
  - the individual must provide verification of training completion at the next periodic review or the family's TANF EDG will be sanctioned, unless good cause exists. The penalty must remain on the EDG until the person(s) provides proof of training completion, has good cause, or is no longer mandatory.

A–2127.4 Failure to Cooperate with Parenting Skills Requirements

Revision 12-3; Effective July 1, 2012

TANF

At the complete review after the individual is referred to parenting skills training, determine if the individual completed the training.

If an individual who continues to meet the mandatory referral criteria does not have verification of class completion, determine if the individual has good cause for not completing the training during the months between reviews.

If an individual no longer meets the mandatory referral criteria when you are verifying training completion, do not determine good cause or impose a full family sanction.

A–2127.5 Good Cause for Parenting Skills Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Use the following chart to determine if good cause exists for the individual.

Good cause exists if ...	Verifications include, but are not limited to ...
no classes were available in the area.	• no classes listed in the Parenting Skills Resource Directory for the area; • a statement from the provider(s) that all classes were full.
the individual currently attends parenting skills training.	a statement or attendance record from the provider.
the person is or was ill and not able to attend an available class.	a doctor's statement or other medical evidence that the person is or was ill and unable to attend during the time when classes were available.
circumstances beyond the individual's control prevented the person from attending and/or completing the class. **Note:** Lack of usual transportation or dependent care is not acceptable for a good cause claim.	a report of a disaster or documentation of a family catastrophe that existed during the time when classes in the area were available.

A–2127.6 Advisor Action on Parenting Skills Noncooperation

Revision 05-3; Effective July 1, 2005

TANF

Apply a full-family sanction for failure to cooperate with the parenting skills requirement.

Follow adverse action procedures in A-2343.1.

A–2127.6.1 Starting a Parenting Skills Penalty

Revision 12-3; Effective July 1, 2012

TANF

Use the chart below to determine when to start a parenting skills penalty.

If the individual fails to comply with the parenting skills requirements at ...	then ...	
complete review,	refer to A-2144, Imposing a Penalty.	
reapplication,	**if the individual ...**	**then ...**
	has an open penalty,	follow procedures in A-2152, Second Noncooperation During Pay For Performance.
	does not have an open penalty,	follow procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reapplication.

A–2127.6.2 Ending a Parenting Skills Penalty or Good Cause

Revision 12-3; Effective July 1, 2012

TANF

Use the policies and procedures in the chart below:

- at a complete review after good cause was approved or a penalty imposed; or
- at an incomplete review if the individual notifies the advisor of training completion.

If the ...	and there is an open parenting skills ...	Then enter ...
individual provides verification of parenting skills training completion,	• good cause; or • penalty	• the month the individual verified training completion as the good cause or penalty end date.
individual provides verification of good cause for the months between reviews,	penalty	• the month the individual verified good cause as the penalty end date; and • begin the good cause. When ending a penalty, enter the month after the individual verifies good cause as good cause start date.
individual does not provide verification of continuing good cause,	good cause	• the month the advisor makes the determination that good cause no longer exists as the good cause end date, and • open a penalty effective the month of disposition. **Note:** Procedures in A-2343.1, How to Take Adverse Action if Advance Notice Is Required.
individual no longer meets the mandatory referral criteria,	• good cause, or • penalty	the month the advisor determines the individual no longer meets the mandatory referral criteria as the good cause or penalty end date.

At each subsequent complete review until all individuals who meet the mandatory referral criteria have completed parenting skills training, continue to:

- refer members to parenting skills training, including members who were added to the EDG since the last complete review;
- verify completion of training;
- verify good cause for not completing the training; and

- impose parenting skills penalties.

A–2128 Alcohol or Drugs

Revision 12-3; Effective July 1, 2012

A–2128.1 When the Person Signs Form H1073

Revision 20-4; Effective October 1, 2020

TANF

Inform a caretaker, second parent, payee or disqualified adult that they will forfeit a month of cash assistance if convicted of a felony or misdemeanor criminal offense under Health and Safety Code, Chapter 481, involving marijuana or another controlled substance or a crime involving abuse of alcohol after signing Form H1073, Personal Responsibility Agreement. This includes a deferred adjudication. The penalty does not apply to an offense that occurred before the person signed Form H1073.

Note: A legal parent is permanently disqualified for a felony drug conviction (not deferred adjudication) for an offense committed on or after April 1, 2002.

Form H1010, Texas Works Application for Assistance — Your Texas Benefits, requires an applicant or recipient to answer a question about a conviction. Accept the person's statement.

Discuss the situation with the person when the criminal history report in the Data Broker system indicates they were convicted of an alcohol or drug offense after signing Form H1073. If they claim not to be the person indicated on the criminal history report, but the identifying information (name, date of birth, physical description) leads staff to believe the information is correct, or the person disagrees with other information provided in the report (such as the type of conviction or whether it was a felony or misdemeanor):

- document the person's response in Case Comments;
- proceed with the appropriate case action without acting on the criminal history report;
- contact the Office of Inspector General (OIG) by emailing the OIG Benefit Program Integrity (BPI) mailbox; and
- document the reason for contacting OIG BPI in Case Comments.

Once OIG BPI obtains information to clear the discrepancy, the assigned OIG BPI investigator provides the information by email. Staff responsible for clearing this task must document the results of the OIG BPI's findings in Case Comments and, if applicable, enter the information in the **Data Collection-Individual Demographic-Conviction/Rehabilitation** page. Make an overpayment referral, if appropriate.

Related Policy
Who Is Not Included, A-222
Disqualified Members, A-232.2
Filing an Overpayment Referral, B-770

A–2128.2 Failure to Cooperate with the Alcohol or Drug Requirement

Revision 12-3; Effective July 1, 2012

TANF

At the complete review after Form H1073 is signed, if the individual answers yes to the question on Form H1010 regarding drugs and alcohol, determine if both the offense and conviction occurred after the individual signed Form H1073. If the offense and conviction occurred after Form H1073 was signed, apply a sanction.

Example 1: An individual signs Form H1073 in January 1999. The individual commits an offense in April 1999 and is convicted in November 1999. At the complete review after November 1999, the individual states on Form H1010 that he was convicted of possessing marijuana or a controlled substance. The advisor must impose a full-family sanction for one month.

Example 2: An individual signs Form H1073 in March. At the next complete review, the individual states he was convicted of a crime involving marijuana. The offense was committed before he signed Form H1073 and the individual was convicted after signing the form. The advisor cannot sanction the household because the offense occurred before the individual signed Form H1073.

A–2128.3 Advisor Action on Noncooperation

Revision 05-3; Effective July 1, 2005

TANF

If the individual states the offense and conviction occurred after signing Form H1073, apply a full-family sanction for one month. Accept the individual's statement as verification.

There is no good cause or cure for noncooperation with the alcohol or drug requirement.

Follow adverse action procedures in A-2343.1.

A–2128.3.1 Starting an Alcohol or Drug Penalty

Revision 12-3; Effective July 1, 2012

TANF

If the individual does not cooperate with the alcohol or drug requirement at a complete review or incomplete review, refer to A-2144, Imposing a Penalty.

Related Policy
Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1

A–2128.3.2 Ending an Alcohol or Drug Penalty

Revision 05-3; Effective July 1, 2005

TANF

End the penalty the month after the forfeit month following procedures in A-2145, Ending An Open Penalty.

A–2129 Good Cause

Revision 19-3; Effective July 1, 2019

TANF

All requirements of the PRA have good cause except for the alcohol and drug requirement. If a person has good cause for any requirement except alcohol and drug, do not penalize the person for noncooperation.

Penalty and good cause start and end dates cannot overlap for Choices, Texas Health Steps, or immunization and parenting skills requirements. The good cause must end before a penalty can start and vice versa.

For more detailed information about good cause start and end dates, refer to each personal responsibility in A-2120, Individual Responsibilities.

A-2130, Form H1073, Personal Responsibility Agreement

Body

Revision 12-3; Effective July 1, 2012

TANF

Form H1073, Personal Responsibility Agreement, lists the recipient's and HHSC's responsibilities. A caretaker, second parent, payee, or disqualified adult must sign Form H1073 before being certified. This includes a minor parent applying as an adult. If a caretaker, second parent, payee, or disqualified adult is not present to sign the agreement during the interview, pend the EDG to obtain the required signature.

Explain Form H1073 responsibilities and penalties for noncooperation at each periodic review.

Once the caretaker or second parent signs Form H1073, they do not have to sign the form again unless they are:

- denied and reapply; or
- added to the EDG.

Note: A disqualified member (as listed in A-222 #4) who cooperates must sign Form H1073 before being added to the TANF EDG. See A-2132.2. A member ineligible for Medicaid because of a Choices or child support noncooperation is not required to sign Form H1073 to reinstate benefits if the cooperation is completed before the end of the second month of noncooperation.

A—2131 Processing the PRA at Application

Revision 12-3; Effective July 1, 2012

A—2131.1 Initial Application

Revision 12-3; Effective July 1, 2012

TANF

At initial application, the individual must:

- sign the PRA; and
- be informed of its requirements and full-family sanction for noncooperation.

Impose a PRA noncooperation if the individual fails to comply with child support, voluntary quit or school attendance requirements after signing Form H1073 but before certification. If the individual cures the noncooperation before the eligibility determination, do not impose the full-family sanction and do not record the penalty.

The month the advisor discovers the noncooperation is also the first month of noncooperation. The applicant must cooperate by the end of the second noncooperation month to avoid reapplying in pay for performance. The forfeit month is the first month the household is otherwise eligible to receive a benefit, including a prorated benefit.

If the individual cooperates by the end of the second noncooperation month, certify the household with a future effective month equal to the month after the forfeit month.

After initial certification, impose a penalty for any PRA noncooperation discovered at complete review or when processing another case action.

If the required member(s) fails or refuses to sign the PRA, deny the application.

Continue to process the application for Medical Programs for Families and Children.

A—2131.2 Applicants Who Previously Received TANF

Revision 12-3; Effective July 1, 2012

TANF

Do not require a member who previously signed Form H1073 to sign it again unless the EDG is denied and the individual reapplies. In this situation, the member must sign Form H1073 again or the application must be denied.

A—2131.2.1 Verifying Prior Cooperation Status at TANF Reapplication

Revision 19-3; Effective July 1, 2019

TANF

When a household reapplies for TANF in the last month the household receives TANF assistance, or the two months following, staff must verify the household was in cooperation with all PRA requirements in the last month the household received TANF cash assistance. If the household was not in cooperation with all PRA requirements in their last month of TANF eligibility, impose a full-family sanction for a minimum of one month or until cooperation, whichever is longer. The month staff discover the noncooperation is also the first month of noncooperation. The applicant must cooperate by the end of the second noncooperation month to avoid reapplying in pay for performance. The forfeit month is the first month the household is otherwise eligible to receive a benefit (including a prorated benefit). If the person cooperates by the end of the second noncooperation month, certify the household with a future effective month equal to the month after the forfeit month. If the household reapplies for TANF later than two months following the month the household last received TANF benefits, treat the household like an initial application.

Related Policy

Texas Health Steps Overdue Month at Application, A-2124.4
Initial Application, A-2131.1

A—2131.3 Imposing a Sanction on a New TANF Household When a Noncooperating Member Moves In

Revision 19-3; Effective July 1, 2019

TANF

When a noncooperating household member certified as an adult moves from an existing household into a new household that is not receiving TANF, but subsequently applies, determine which PRA requirement(s) the member did not cooperate with and use the following chart to determine what action to take.

If the adult ...	then ...	Follow policy in ...
did not cooperate with Choices, child support or voluntary quit,	the new household is considered to be applying in pay for performance.	A-2151, Open Penalty at Reapplication in Pay for Performance.
did not cooperate with parenting skills and moves into a household that includes a child under age 5,	the new household is considered to be applying in pay for performance.	A-2151, Open Penalty at Reapplication in Pay for Performance.
did not cooperate with parenting skills and moves into a household that does not include a child under age 5,	treat the household as an initial application.	A-2131.1, Initial Application.
moves from an existing household with a child who is not meeting Texas Health Steps, immunization, school attendance, or parenting skills requirements,	the household is considered to be applying in pay for performance.	A-2151, Open Penalty at Reapplication in Pay for Performance.
did not cooperate with any other PRA requirement,	treat the household as an initial application.	A-2131.1, Initial Application.

Note: If a noncooperating minor parent certified as a caretaker, second parent or disqualified person is not in compliance with school attendance and moves from an existing household into a new household, follow policy in A-2151, Open Penalty at Reapplication in Pay for Performance.

When a household member certified as a child moves from an existing household into a new household that currently is not receiving TANF, but subsequently applies and the child has an open PRA noncooperation for immunizations, Texas Health Steps or school attendance, do not impose a full-family sanction on the new household. Follow policy in A-2131.1, Initial Application.

If the noncooperating household member moves back into the original household, follow policy A-2132.5.

Related Policy

Open Penalty at Reapplication in Pay for Performance, A-2151.

A—2132 Processing Changes

Revision 12-3; Effective July 1, 2012

A—2132.1 Addition of a Caretaker or Second Parent at Incomplete Review

Revision 12-3; Effective July 1, 2012

TANF

Require the new member to sign Form H1073 within 10 days of the report date when adding a caretaker, second parent, payee or disqualified adult at incomplete review. If the new member refuses or fails to sign Form H1073, deny the EDG. Apply the full-family sanction policy if the member noncooperates with the PRA requirements after signing the PRA.

A—2132.2 Disqualification of a Caretaker or Second Parent

Revision 12-3; Effective July 1, 2012

TANF

If, after the PRA is signed, the caretaker is disqualified or both parents are disqualified in a two-parent household, inform the household of the payee/disqualified adult PRA requirements.

When the household consists of both the caretaker and second parent who have signed Form H1073 and only one parent is disqualified, the PRA requirements still apply to the household. When the disqualified member cooperates, the individual must sign Form H1073 before being added to the TANF EDG.

Note: This policy does not apply to members who are ineligible for Medicaid because of a noncooperation with PRA Choices or child support.

A—2132.3 Removing a Penalized Member During the First Noncooperation Month

Revision 12-3; Effective July 1, 2012

TANF

If the household reports the move ...	then...
before the PRA noncooperation is imposed,	do not apply a full-family sanction to the household. Record the penalty for the noncooperating individual.*
after the PRA noncooperation is imposed and the advisor verifies the member moved out of the household before the second month,	apply a full-family sanction to the household for one forfeit month only.

***Note:** The noncooperation is recorded with the individual's information only. TIERS will not set a Non Cooperation One (NC1) month until the individual reapplies.

A—2132.4 Removing a Penalized Member During the Second Noncooperation Month

Revision 12-3; Effective July 1, 2012

TANF

Deny the TANF EDG if the penalized member failed to cooperate and moved out during the second noncooperation month or afterwards. The household must reapply for TANF.

If the household reapplies for TANF and a member of the applying household

- has an open PRA penalty, the household must demonstrate PRA cooperation for one month through pay for performance.
- does not have an open penalty, the household does not have to demonstrate cooperation.

A—2132.5 Adding a Penalized Member to a Household

Revision 12-3; Effective July 1, 2012

TANF

A household currently receiving TANF cannot receive a benefit for the new penalized member for the identified forfeit month(s). Pend the EDG to add the penalized member for 30 or 40* days after the change is reported to allow demonstrated cooperation.

If the penalized member ...	then ...
demonstrates cooperation by the 30th or 40th day,	add the new member to the TANF EDG following current change policy, but no earlier than the month after the forfeit month(s).
fails to demonstrate cooperation by the 30th or 40th day,	Deny the EDG.**

*Follow policy in A-2151, Open Penalty at Reapplication in Pay for Performance, to determine if the EDG should be pended for 30 or 40 days.

**TIERS will transfer sanction information on the individual to the new case/EDG from the old case/EDG so there will be no change to NC1, Non Cooperation 2 (NC2), Forfeit 1 or Forfeit 2.

Provide a separate Form H1020, Request for Information or Action, Request for Information or Action, if other eligibility verification is required. If all eligibility information is provided except PRA cooperation, add the new member to the SNAP or Medicaid EDG as appropriate.

Example: On May 3, the Smith household requests that Sarah, who is a new member of the household and currently penalized, be added to their EDG. The advisor sends form H1020 to the household informing them that Sarah has an open penalty and cannot be added until she cooperates with the PRA. If the household fails to provide verification of cooperation by June 2, the advisor sends Form TF0001, Notice of Case Action, to deny the TANF cash assistance. Take action on any associated Medicaid or SNAP EDGs following existing policy.

A—2132.6 Certified Children Who Age Out Before/After the Caretaker or Payee Fails to Cooperate with PRA Requirements

Revision 12-3; Effective July 1, 2012

TANF

Once a certified child ages out of the certified group, the caretaker or payee is not required to cooperate with the PRA requirements for that particular child even if timely action has not been taken to remove the child from the EDG.

When a caretaker or payee receives a noncooperation for a certified child ...	then ...
and the certified child ages out before the noncooperation discovery month,	do not sanction the household.
and the certified child ages out during or after the noncooperation discovery month,	ensure the child is removed from the EDG and apply one forfeit month to the household.

Notes:

- Process an overpayment referral if the child was not removed timely from the EDG.
- A child ages out in the month the child turns 18 or the month the child graduates if graduating before or during the month of the individual's 19th birthday.

A-2140, Full-Family Sanction

Body

Revision 12-3; Effective July 1, 2012

TANF

Impose a full-family sanction when an adult TANF recipient, minor parent certified as an adult or second parent, or payee/disqualified adult fails to cooperate with any applicable requirement of the PRA after the agreement has been signed. The full-family sanction is imposed for a minimum of one month or until cooperation, whichever is longer.

If the household does not cooperate with a PRA requirement for two consecutive months, the household loses TANF cash assistance and the family must demonstrate cooperation with the PRA for 30 days before receiving cash assistance again. This is referred to as pay for performance.

If the household does not cooperate with two or more PRA requirements during the initial NC1 or NC2 month, the household loses TANF cash assistance and the family must reapply in pay for performance.

A—2141 When to Start a Full-Family Sanction

Revision 12-3; Effective July 1, 2012

TANF

After the TANF recipient or payee/disqualified adult signs the PRA, the entire household loses eligibility for cash assistance if a:

- TANF recipient fails to cooperate with **any** PRA requirement, or
- payee/disqualified adult fails to cooperate with any of the modified PRA requirements.

This loss of cash assistance is referred to as a full-family sanction. During the full-family sanction the household is ineligible for cash assistance for one month or until they cooperate, whichever is longer. Once the full-family sanction is imposed, that month's benefit is forfeited and the family cannot regain that month's benefit, even if they later cooperate.

If the nonexempt TANF recipient fails to cooperate with Choices or child support, or the payee/disqualified adult or Choices-exempt TANF recipient fails to cooperate with child support, the noncooperating individual also loses Medicaid coverage (excluding Transitional Medicaid) for one month or until cooperation, whichever is longer, unless the individual is under age 19 or pregnant. The other family members remain eligible for Medicaid.

A noncooperation is not applicable if the noncooperation occurred:

- before Sept. 1, 2003, and the full-family sanction was never imposed, or

- on or after Sept. 1, 2003, but before signing Form H1073. Advisors must not open anew PRA penalty for noncooperations that occurred before the individual signed the PRA.

Notes:

- After the TANF EDG is denied for any reason, the noncooperating adult may reapply for Medicaid and qualify after the identified forfeit months. **Exception:** An adult who noncooperated with child support must comply before becoming eligible for Medicaid.
- If the family has new or increased earnings, child support income or loss of the 90% earned income disregard (EID) that causes ineligibility and a PRA noncooperation that affect the same month, the earned income, child support or EID change has hierarchy. **Exception:** Legal parents who fail to cooperate with Child/Medical Support or TPR requirements are not eligible for Transitional Child Support Medicaid.

Related Policy

Transitional Medicaid Coverage, A-840

A—2141.1 Determining the First Month of Noncooperation

Revision 14-1; Effective January 1, 2014

TANF

The first month of noncooperation, or the NC1 month, is the month:

- of the "noncooperation date" on Form H2581, Choices Noncooperation Report;
- HHSC receives notice of child support noncooperation on Form H1708-A, Report of Noncooperation (Automated). **Note:** There is no noncooperation date on Form H1708-A. Use the date the data is posted to the online system; or
- the advisor discovers noncooperation with other PRA requirements at either a complete or incomplete action.

A—2141.2 Determining the Second Month of Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

The second month of potential noncooperation/cooperation, or the NC2 month, is the calendar month following the first month of noncooperation. The family must cooperate with the PRA by the last calendar day of the second month to avoid a second forfeit month and pay for performance requirements.

Consider the individual a TANF recipient during the second month of noncooperation even if this is a forfeit month. The individual has not lost eligibility during the second month of noncooperation and may regain eligibility during the second month if cooperation is established by the last calendar day of the month.

Note: When a member fails to cooperate with the drug and alcohol PRA requirement, the individual is considered to be back in cooperation status the month after the month of noncooperation unless convicted of a subsequent offense.

A—2141.3 Determining the Forfeit Month(s)

Revision 12-3; Effective January 1, 2012

TANF

For PRA penalties imposed on active EDGs, the first month the advisor can actually apply the full-family sanction and forfeit a month of TANF cash assistance after sending Form TF0001, Notice of Case Action, and allowing adverse action is the effective month.

For PRA penalties imposed at application, the first forfeit month for:

- TANF is the first month the household would otherwise receive a TANF grant.
- Medicaid for an adult who fails to cooperate with Choices or child support is the first month the advisor can impose the penalty on or after the PRA noncooperation discovery date. Provide Medicaid coverage for the adult for any eligible months before the PRA noncooperation discovery date.

Note: Forfeit months cannot be prior to the first noncooperation (NC1) month.

A TANF household that fails to cooperate with the PRA for two consecutive months must forfeit cash assistance for two consecutive months. The following individuals also forfeit Medicaid coverage for two consecutive months, unless the individual is pregnant or under the age of 19:

- Choices mandatory TANF caretaker or second parent who noncooperates with Choices or child support;
- Choices exempt TANF caretaker or second parent who noncooperates with child support; or
- payee/disqualified adult who noncooperates with child support.

Note: When the full-family sanction month has been determined and a Choices or child support noncooperation is received after cutoff in the first month of noncooperation, disqualify the noncooperating member the next effective month.

A—2142 Applying a Full-Family Sanction to Multiple TANF EDGs

Revision 19-3; Effective July 1, 2019

TANF

If the TANF recipient, payee, or disqualified adult has more than one TANF EDG and fails to cooperate with:

- parenting skills, voluntary quit or Choices, the sanction applies only to the EDG with the certified adult;
- Texas Health Steps, immunizations or school attendance, the sanction applies to the EDG with the applicable child; or
- child support or drugs and alcohol, the sanction applies to all TANF EDGs.

A—2143 Reinstating Cash Assistance After Cooperation

Revision 14-1; Effective January 1, 2014

TANF

If the family cooperates with all required PRA components by the last calendar day of the second consecutive month, the advisor must reinstate TANF cash assistance for the first month after the full-family sanction month. If the advisor receives verification of cooperation from the individual, Texas Workforce Commission (TWC), Office of Attorney General (OAG) or other sources after the second month and before cutoff of the following month, the individual must have cooperated in the second month to have cash assistance reinstated. **Note:** If HHSC later receives proof that the individual did cooperate in the second month, the individual may reapply without going through the pay for performance process.

Example: The advisor receives Form H1708-A, Report of Noncooperation (Automated), in November after cutoff and processes the EDG before December cutoff. The family's first month of noncooperation is November, and the full-family sanction is effective January. The family has forfeited January TANF cash assistance permanently. The noncooperating adult has also lost Medicaid for January.

The family's second consecutive month of noncooperation/cooperation is December. On Jan. 4, the OAG provides Form H1701, Child Support, TANF Foster Care and TANF/Medicaid Case Information Exchange, verifying the individual cooperated with child support requirements on Dec. 29, 2003. The advisor must reinstate TANF cash assistance (and Medicaid for the disqualified adult) effective February (the month after the forfeited month).

A—2144 Imposing a Penalty

Revision 14-2; Effective April 1, 2014

To impose a penalty, ensure required individuals have signed Form H1073, Personal Responsibility Agreement. Impose a full-family sanction using the following chart.

If processing ...	impose a full-family sanction ...
an initial application,	effective the first month the applicant would otherwise receive a grant if the individual does not cooperate with child support, voluntary quit or school attendance requirements before certification but after signing the PRA. Do not impose a full-family sanction for any other noncooperation at application.
an incomplete review,	the effective month based on the date Form TF0001, Notice of Case Action, is sent if the individual does not cooperate with Choices, child support or voluntary quit requirements.
a complete review on an active EDG,	the effective month based on the disposition date for any penalty.

If processing ...	impose a full-family sanction ...
a reapplication after denial,	as explained in each individual responsibility section (A-2120, Individual Responsibilities).
an application received in the last benefit month or within two months after the last benefit month,	effective the first month the applicant would otherwise receive a grant if the applicant was not cooperating with the PRA in the last benefit month (A-2131.2.1, Verifying Prior Cooperation Status at TANF Reapplication).

Issue Form TF0001, informing the individual of the PRA noncompliance. Include who did not comply with the PRA and which requirement the member failed to cooperate with.

Note: Impose a full-family sanction if the requested verification indicates the PRA requirement was met after the verification request date or if the verification is provided after the verification due date.

A—2144.1 Failing to Impose a Full-Family Sanction

Revision 12-4; Effective October 1, 2012

TANF

If HHSC does not take action on a noncooperation report within a reasonable time frame, send Form TF0001, Notice of Case Action, to initiate the noncooperation penalty as soon as possible.

Form TF0001 is sent within a reasonable time frame if:

- for Choices penalties, a Choices penalty notice is received from TWC within five calendar days after the end of the month in which the Choices noncooperation occurred; and
- for all penalties, the advisor sends Form TF0001 in the same calendar month as the date of noncooperation, or within 10 calendar days after becoming aware of the noncooperation if that is later.

If the advisor does not send Form TF0001 within a reasonable time frame, the first month of noncooperation becomes the month Form TF0001 was sent. This ensures the individual has a reasonable opportunity to demonstrate cooperation in the second month.

Note: A postponed first month results in a forfeit month, but does not count toward two consecutive months of noncooperation.

If the advisor sends Form TF0001 for a PRA penalty within a reasonable time frame but fails to timely impose the full-family sanction for the correct forfeit month, determine the actual first and second month of noncooperation. If the individual:

- cooperates in the second month, file a claim for the month that should have been forfeited. The household does not need to reapply for TANF.
- fails to cooperate in the second month, file a claim for the two months that should have been forfeited. The household must reapply in pay for performance status.

If a penalty is applicable but the EDG is denied, advisors still must enter the penalty information into TIERS and send Form TF0001.

A—2145 Ending an Open Penalty

Revision 12-3; Effective July 1, 2012

TANF

The end date for a PRA penalty is the month the individual cooperates or has good cause for certain PRA requirements.

Close a PRA penalty if the household cooperates by the end of the second month of noncooperation and provides verification by cutoff of the next month.

If verification is provided after cutoff of the following month, the household must reapply as explained in A-2143.

Note: Do not close a child support penalty incurred while receiving TANF when an individual applies for adult Medicaid and has cooperated with the OAG.

The end date cannot be later than the effective month (the month the advisor can affect benefits).

Enter the verification type and date when ending a penalty. If the advisor enters an end month with no verification, TIERS pends the page.

Note: If after imposing a penalty you determine the individual was incorrectly penalized, remove the penalty and restore benefits, if appropriate.

A—2146 Action When a Person Fails to Cooperate with the PRA at Complete or Incomplete Review

Revision 19-3; Effective July 1, 2019

TANF

If the caretaker, second parent, payee or disqualified adult noncooperates with ...	then ...
Choices (Caretakers and second parents only)	• The first month of noncooperation is the month of the "noncompliance date" on Form H2581, Choices Noncooperation Report. • Refer the noncooperating adult to the workforce solutions office. Do not require a signed Form H2580, TANF Employment Services Notice. • Send Form H2581 response to TWC with the current appropriate response. • Send Form TF0001, Notice of Case Action, within five workdays after receiving Form H2581. • Terminate the TP 08 of the noncooperating adult, unless the person is pregnant or under age 19. **Note:** TIERS will set the Work Registration Reason as "Sanctioned for Choices nonparticipation" for the noncooperating adult(s).
Child support	• The first month of noncooperation is the month HHSC receives Form H1708-A, Report of Noncooperation (Automated). • Send Form TF0001 within five workdays after receiving Form H1708-A. • Terminate the TP 08 of the noncooperating adult unless the person is pregnant or under age 19.
Texas Health Steps, immunizations, school attendance, parenting skills or voluntary quit	• The first month of noncooperation is the month staff discover the noncooperation. • Send Form TF0001.
Drugs and alcohol	• The first month of noncooperation is the month staff discover the drug and alcohol conviction. • Send Form TF0001.

Note: See A-2147, Action When the Person Cooperates with the PRA Requirements Before the End of the Second Noncooperation Month, for situations where the person cooperates with the PRA requirements before the end of the second potential noncooperation month. If the person provides other information needed to complete the review and cooperates with the PRA requirement, complete the review and impose a full-family sanction. End-date the penalty effective the month the person cooperates.

Related Policy

Imposing a Penalty, A-2144
Action When the Individual Cooperates with the PRA Requirements Before the End of the Second Noncooperation Month, A-2147
PRA Requirements Before the End of the Second Noncooperation Month, A-2147
Recipients of TANF and TP 08, A-825.1

A—2147 Action When the Individual Cooperates with the PRA Requirements Before the End of the Second Noncooperation Month

Revision 12-3; Effective July 1, 2012

TANF

If the caretaker, second parent, payee or disqualified adult cooperates with the PRA requirement before the end of the second noncooperation month, then end date the penalty effective the month the individual cooperates. Send Form TF0001, Notice of Case Action, informing the household the sanction has ended and the ongoing benefit amount.

Notes:

- For Choices and child support, end the Medicaid disqualification the month the individual cooperates. Reinstate Medicaid benefits effective the month after the forfeit month.
- If after imposing a penalty, it is determined the individual was incorrectly penalized, remove the penalty and restore benefits, if appropriate.
- If the household cooperates with the PRA requirements but does not provide information requested to complete the periodic review, deny the household for failure to provide.

A—2148 Reserved for Future Use

Revision 12-3; Effective July 1, 2012

A—2149 Individual Notices

Revision 14-2; Effective April 1, 2014

TANF

Issue Form TF0001, Notice of Case Action, to impose a full-family sanction. Issue a second Form TF0001 for any PRA noncooperation that occurs in the first or second month of noncooperation after the original noncooperation has been identified to inform the household of the new noncooperation. Advise the household of the penalty and how the member can cooperate.

Use adequate notice when imposing a penalty for one or more PRA noncooperations. See A-2344.1, Form TF0001 Required (Adequate Notice).

A-2150, Pay for Performance

Body

Revision 12-3; Effective July 1, 2012

TANF

If the household does not cooperate with one or more PRA requirements for two consecutive months, the household loses TANF cash assistance and the family must demonstrate cooperation with all PRA requirements for 30 days before they are eligible to receive TANF cash assistance. This is referred to as pay for performance. Advisors must verify that the family has not cooperated by the end of the second consecutive month before applying the pay for performance policy. The 30 days of demonstrated cooperation starts when the family cooperated with the PRA requirement. **Note:** If cooperation was established before the application date, the 30 days of cooperation begins on the file date.

A household may reapply for TANF assistance under pay for performance after the second noncooperation month. Deny a TANF application, filed before the last day of the second noncooperation month as filed in error. **Exception:** Do not deny the TANF application if the appointment is scheduled after the second noncooperation month. At the interview, have the individual review Form H1010 and re-sign it. The file date is the first day of the interview month. Document the reason the file date changed.

Note: When a TANF applicant with an open PRA penalty applies for One-Time Temporary Assistance for Needy Families (OTTANF), the individual must demonstrate cooperation with all open noncooperations before being considered TANF-eligible. See A-2400 for OTTANF policy.

A—2151 Open Penalty at Reapplication in Pay for Performance

Revision 19-3; Effective July 1, 2019

TANF

If the TANF applicant or second parent is in pay for performance status because of failure to cooperate with ...	then ...
Choices	The person must cooperate with Choices requirements for 30 days if they are not eligible for a Choices exemption. Refer the person to the local workforce solutions office with Form H2588, Workforce Orientation Referral, indicating they are subject to pay for performance. Remind the person to contact the local workforce solutions office within 10 days to allow enough time to demonstrate 30 days of cooperation. Pend the application until the 40th day after the interview date, and: • end the penalty the month of cooperation if notice of cooperation is received by the 40th day after the interview date and certify the application effective the: ◦ month after the second forfeit month; or ◦ 30th day from the file date if after the second forfeit month; or • deny the application if the workforce solutions office: ◦ has not sent a notice of cooperation by the 40th day after the interview date; or ◦ send Form H2588 indicating the person cannot demonstrate 30 days of cooperation before the 40th day after the interview date. The person must complete another application and restart the eligibility process. **Note:** Choices staff will sign off on the Form H2588 after the person attends the workforce orientation. Staff should not end a Choices penalty until an electronic notice of demonstrated cooperation is received through the automated interface.
Child support	The person must cooperate with child support requirements. Refer the person to the OAG and pend the application until the 30th day after the file date. If the person: • complies by the 30th day after the file date, end the penalty the month of cooperation and continue pending the application until the 30th day after the cooperation date and certify the application effective the: ◦ month after the second forfeit month; or ◦ 30th day from the file date if after the second forfeit month; or • has not complied with the OAG by the 30th day after the file date, deny the application.
Voluntary quit	The person must cure the voluntary quit. Verify the person has obtained employment of 30 hours or more per week, or is eligible for a Choices exemption. If the person is employed on the interview date or is eligible for a Choices exemption, pend the application until the 30th day after the file date for proof of cooperation, and if the person: • complies by the 30th day after the file date, end the penalty the month verification is provided, continue pending the application until the 30th day after the cooperation date and certify the application effective the: ◦ month after the second forfeit month; or ◦ 30th day from the file date if after the second forfeit month; or • is not employed for 30 hours per week or eligible for a Choices exemption, deny the application.
Texas Health Steps	The person must cooperate with Texas Health Steps requirements. Refer the person to the local Texas Health Steps staff using Form H1087, or Texas Health Steps regional hotline. Pend the application until the 30th day after the file date for proof of cooperation, and if: • the person complies by the 30th day after the file date, end the penalty the month the person provides verification of medical screening and continue pending the application until the 30th day after the cooperation date. Certify the application effective the: ◦ month after the second forfeit month; or ◦ 30th day from the file date if after the second forfeit month; or • verification is not provided by the 30th day after the file date, deny the application.

If the TANF applicant or second parent is in pay for performance status because of failure to cooperate with ...	then ...
Immunizations	The person must cooperate with immunization requirements. Pend the application until the 30th day after the file date for proof of cooperation. If: • the person cooperates by the 30th day after the file date, end the penalty the month verification is provided and continue pending the application until the 30th day after the cooperation date. Certify the application effective the: ◦ month after the second forfeit month; or ◦ 30th day from the file date if after the second forfeit month; or • verification is not provided by the 30th day after the file date, deny the application.
School attendance	The person must cooperate with school attendance requirements. Pend the application until the 40th day after the interview date, and • end the penalty the month school attendance is verified and certify the application effective the: ◦ month after the second forfeit month; or ◦ 30th day from the file date if after the second forfeit month; or • deny the application if verification is not provided by the 40th day after the interview date.
Parenting skills	The person must cooperate with parenting skills requirements. Pend the application until the 30th day after the file date, and if • the person cooperates by the 30th day after the file date, end the penalty the month completion is verified and continue pending the application until the 30th day after the cooperation date. Certify the application effective the: ◦ month after the second forfeit month; or ◦ 30th day from the file date if after the second forfeit month; or • verification is not provided by the 30th day after the file date, deny the application.
Drugs and alcohol	When a person fails to cooperate with the drug and alcohol PRA requirement, the person is considered as back in cooperation status the month following the month of noncooperation, unless staff discover a second separate noncooperation in the month following the first noncooperation month. See A-2128.

Notes:

- When pending the EDG for verification of cooperation with PRA requirements, other than Choices or school attendance, document the following in the comments section of Form H1020: Your application cannot be certified earlier than the 30th day from the date of cooperation with (enter the PRA requirement). Su solicitud sólo se puede certificar 30 días después de la fecha de cumplimiento con los requisitos relacionados con (enter the PRA requirement).
  - Child Support – la manutención de niños
  - Voluntary Quit – la renuncia voluntaria al trabajo
  - Texas Health Steps (enter name of child) – Pasos Sanos de Texas (enter name of child)
  - Immunizations (enter name of child) – las inmunizaciones (enter name of child)
  - Parenting Skills – la capacitación para ser buenos padres
  - Drugs/Alcohol – las drogas y el alcohol

Note: TIERS automatically documents this information on the Form H1020.

- If the person reapplies in pay for performance, but does not have any open penalties, the 30 days of cooperation begins on the file date.
- Explore Medicaid eligibility for the children and eligible adults.
- If a person has an open Choices, Voluntary Quit or Parenting Skills penalty and is now a payee, the person does not have to demonstrate cooperation.

A—2152 A Second Noncooperation During Pay for Performance

Revision 12-3; Effective July 1, 2012

TANF

The household must reapply in pay for performance to qualify for TANF cash assistance. An individual with an open penalty at application must cooperate with the PRA requirement that caused the penalty and demonstrate PRA cooperation for 30 days.

When a household reapplies for TANF during pay for performance and the advisor discovers a household member fails to cooperate with a second or subsequent PRA requirement:

- Before or during the reapplication interview, allow the individual to demonstrate cooperation for the initial and second or subsequent noncooperation. Pend the application for the required 30- or 40-day time period to allow demonstrated cooperation for the initial and second or subsequent penalty. If the household:
  - cooperates with both the initial and subsequent penalties, close the initial penalty and certify the application. Document that the household cooperated with the second or subsequent penalty.
  - cooperates with the initial penalty, but not second or subsequent penalty, close the initial penalty, open the second or subsequent penalty and deny the application as a result of the second or subsequent noncooperation.
  - fails to cooperate with the initial penalty, leave the penalty open and deny the application. Do not open a second or subsequent penalty.
- After the interview, deny the TANF reapplication. The initial penalty remains open. Open the second or subsequent penalty.

Note: Explore Medicaid eligibility for the children and eligible adults.

A-2160, Verification Requirements

Body

Revision 08-3; Effective July 1, 2008

TANF

Verify a good cause claim as explained in A-2129, Good Cause.

Immunizations

Verify:

- that the child's immunizations are current;
- that a child is enrolled and attending school, unless there is other information that the child is not up-to-date with his immunizations; and
- prior cooperation status at reapplication, according to A-2125.5.1, Starting an Immunization Penalty.

A—2161 Verification Sources

Revision 19-3; Effective July 1, 2019

TANF

Texas Health Steps

- Checking the Texas Health Steps Overdue MED DT in TIERS Data Collection
- Verification from the person such as a doctor's statement
- Verification from Texas Health Steps staff
- Form H1087, Verification of Texas Health Steps Checkup

Immunizations

- Form H1012, Immunization Record
- Statement from a medical provider such as a doctor or nurse
- Verification that a child is enrolled and attending school, unless there is other information that the child is not up-to-date with immunizations

Parenting Skills

- Form H1088, Verification of Parenting Skills Training
- Training certification, letter or Women, Infants and Children (WIC) identification card that verifies completion of parenting skills training

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A-2170, Documentation Requirements

Body

Revision 19-4; Effective October 1, 2019

TANF

Document:

- that staff verbally explained the personal responsibility agreement (PRA) requirements to the person according to A-2110, General Policy; and
- the reason for good cause, if applicable.

Parenting Skills

Document the name, address, and a phone number for the contact person of the organization or person who provided the training.

Drugs and Alcohol

Document the:

- person's response when they disagree with the information in a credit report, including the information the person states is incorrect; and
- reason for referral to OIG.

A-2200, Workforce Orientation

A-2210, Requirements

Body

Revision 05-5; Effective October 1, 2005

TANF and TANF-SP

A caretaker and second parent (not disqualified) residing in a full service Choices county must attend a workforce orientation if he is applying for

- TANF/TANF-SP, or
- extended TANF.

Inform the applicant that he must attend the orientation before you can certify the household.

List the requirement to provide proof of workforce orientation attendance on Form H1020, Request for Information or Action.

See A-2214, Failure or Refusal to Comply with the Workforce Orientation Requirement. When denying a TANF/TANF-SP application for failure to attend workforce orientation, continue to process the application for Medical Programs for Families and Children and for the Supplemental Nutrition Assistance Program (SNAP), if applicable.

Some applicants may not be able to attend a regularly scheduled workforce orientation due to extraordinary circumstances. These applicants must complete an alternative workforce orientation via telephone or home visit by local workforce staff depending on available resources. **Exception:** Allow good cause for a caretaker/second parent who is unable to complete a regular or alternate workforce orientation because of being hospitalized or bedridden with a severe illness.

A—2211 Alternative Workforce Orientation

Revision 12-3; Effective July 1, 2012

TANF and TANF-SP

At the interview, inform applicants who cannot attend a regularly scheduled workforce orientation due to extraordinary circumstances that he must complete an alternative orientation. Inform the client that he must contact the workforce solutions office to request an alternative orientation. Extraordinary circumstances may include:

- no available transportation or a disruption in transportation arrangements;
- residing more than 30 miles from the nearest Local Workforce Development Board (LWDB) orientation site;
- caring for a child under four months of age;
- a conflicting work or school schedule;
- illness or injury of the applicant or spouse;
- illness or injury of another household member that requires the applicant's care; or
- being a victim of family violence and attending the orientation session would place the applicant/family in danger.

Generally, the alternative workforce orientation will consist of either a telephone call or a visit by local workforce staff. The type of alternative orientation will depend on resources available to the LWDB.

A—2212 Workforce Orientation Referral

Revision 03-5; Effective July 1, 2003

A—2212.1 Form H2588, Workforce Orientation Referral

Revision 12-3; Effective July 1, 2012

TANF and TANF-SP

Use Form H2588, Workforce Orientation Referral, to refer an applicant in a full service Choices county to a regular or alternative workforce orientation. Provide the applicant with a completed Form H2588 for each caretaker and second parent.

Note: If you determine the applicant requires an alternative workforce orientation, complete Form H2588, Part B – Workforce Orientation (Alternative).

Inform individuals of the requirements to

- attend a workforce orientation, regular or alternative, and
- have Form H2588 signed and stamped by Choices staff.

Choices staff are required to return the verification to the local eligibility determination office by fax, phone, courier, interagency mail, or regular mail.

If the Local Workforce Development Board (LWDB) determines they are not able to accommodate the applicant with an alternative orientation, the LWDB returns Form H2588 indicating they were not able to provide the orientation and that the applicant is considered to have met the requirement.

Note: The applicant may choose to return the stamped Form H2588 to HHSC instead of waiting for Choices staff to provide the verification to HHSC.

A—2212.2 Workforce Orientation Flyers

Revision 13-4; Effective October 1, 2013

TANF and TANF-SP

Choices staff provide offices with workforce orientation flyers. The flyers for the regular orientation informs applicants of the days, times, and locations of regular workforce orientation sessions. The LWDBs have flexibility in the development of the alternative workforce orientation flyer. If the flyer does not contain information regarding an alternative orientation, provide the applicant with the regular orientation flyer so they have the workforce solutions office's telephone number. Advisors must inform the individual that it is the individual who must contact the workforce solutions office to request an alternative workforce orientation. Provide a workforce orientation flyer, regular or alternative, with each Form H2588, Workforce Orientation Referral.

Advisors are not required to provide a TANF Workforce Orientation flyer with Form H2588 to TANF applicants who are interviewed by phone from a remote location, although this remains an acceptable option. At a minimum, advisors must provide the household with the workforce solutions office information based on the individual's residential address.

Staff can find the most accessible workforce solutions office for the household at www.twc.state.tx.us and clicking on "Find Locations."

Staff must list the requirement to provide proof of workforce orientation attendance on Form H1020, Request for Information or Action, Request for Information or Action, along with the contact information, address and phone number for the workforce solutions office. The

applicant is responsible for making contact with the workforce solutions office and completing the workforce orientation.

The number of available orientations depends on the number of applicants local eligibility determination offices refer to Choices staff. Texas Works and Choices staff coordinates to determine the average number of referrals. Regular workforce orientations occur at least twice a week. Rural areas of full service Choices counties may hold orientations on an individual basis.

Note: If a workforce orientation, regular or alternative, is unavailable to an applicant in a full service Choices county within the 10-day pending period, do not require the applicant to attend the workforce orientation prior to certification.

A—2213 Workforce Orientation Session

Revision 03-5; Effective July 1, 2003

TANF and TANF-SP

The workforce orientation, regular and alternative, introduces applicants to the local labor market and the resources available to assist the applicant with finding a job. Workforce orientation emphasizes the impact of time-limited benefits, importance of work, and personal responsibility.

Workforce orientation staff informs applicants of related support services, such as childcare and limited transportation benefits.

A—2213.1 Related Support Services

Revision 03-5; Effective July 1, 2003

TANF and TANF-SP

Choices staff in a full service Choices county offer applicants the opportunity to take advantage of immediate job search or education/training resources. If the applicant attends the regular or alternative orientation and obtains a job before TANF certification, Choices staff offers an applicant childcare for up to 12 months and limited transportation benefits.

Once certified, the individual may receive childcare and limited transportation benefits if he gets a job within the first three months after TANF certification and if the household is not eligible for transitional benefits. If the individual gets a job after receiving TANF benefits for more than three months, the household is potentially eligible for transitional benefits.

A—2213.2 Employment Planning Session (EPS)

Revision 03-5; Effective July 1, 2003

TANF and TANF-SP

At the end of the workforce orientation, regular or alternative, Choices staff in full service Choices counties give or mail an EPS appointment to all applicants.

Some applicants are not required to attend the EPS. Choices staff let the applicant know if he must attend the EPS. Mark the "Potential Choices Status" box on Form H2588, Workforce Orientation Referral, to help local Choices staff determine who is potentially exempt or non-exempt from the Choices program and the EPS.

Local Choices staff advise applicants who are potentially

- non-exempt from Choices about sanctions for not attending the EPS.
- exempt from Choices that they do not have to attend the EPS but may volunteer to attend.

In most instances, Choices staff hold the EPS after the advisor certifies the TANF case; however, Choices staff may hold the EPS before TANF certification.

If the individual ...	then Choices staff ...
attends the EPS after certification,	set the appointment date as the date the individual attends the EPS.
fails to keep the EPS appointment after certification,	send a sanction request for a non-exempt TANF recipient. This counts as a Choices noncompliance.

If the individual ...	then Choices staff ...
attends the EPS before certification,	set the appointment date as the certification date.
fails to keep the EPS appointment before certification,	do not initiate a sanction. Instead, send another EPS appointment notice after case certification.

A recipient exempt from participating in Choices is not required to attend the EPS. By attending, the individual is voluntarily participating in the Choices program and is subject to time limits.

Related Policy

State Time Limits, A-2500

A—2214 Failure or Refusal to Comply with the Workforce Orientation Requirement

Revision 13-1; Effective January 1, 2013

TANF and TANF-SP

Deny an application or EDG if a required adult member in a full service Choices county fails to attend the regular workforce orientation or complete an alternative orientation.

A—2215 Addition of a New Household Member or Disqualified Member

Revision 13-1; Effective January 1, 2013

TANF and TANF-SP

When adding a new member or a household member previously disqualified for another reason, require that member to attend a workforce orientation.

A-2220, Verification Requirements

Body

Revision 08-3; Effective July 1, 2008

TANF and TANF-SP

Verify workforce orientation attendance with:

- information provided by Choices staff; or
- a procedure established through a local region and Workforce Development Board Memorandum of Understanding.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A-2230, Documentation Requirements

Body

Revision 12-3; Effective July 1, 2012

TANF and TANF-SP

Document the good cause reason when a caretaker/second parent is unable to complete a regular or alternate workforce orientation. See A-2210, Requirements.

Document verification obtained by phone or through an agreed procedure between the local region and Local Workforce Development Board (LWDB) staff.

Example: The LWDB provides rural offices with a workforce orientation video. Document the workforce orientation requirement was met with the viewing of the workforce orientation video.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

A-2300 Case Disposition

A-2310, Notice to Applicants

Body

Revision 26-1; Effective Jan. 1, 2026

All Programs

The Eligibility Determination Group (EDG) disposition produces the person's notice of eligibility status. After the interview or during processing of the application or renewal form, the EDG is pended, certified, sustained or denied. After disposition, provide one or more of the following notices, as applicable:

- Form H1020, Request for Information or Action , tells the applicant the:
  - reason the case is pending;
  - action the applicant or staff must take;
  - date when the applicant or staff must take action; and
  - date staff must deny the application or EDG if the person does not take action, if applicable.

Note: For those who are Spanish speaking only, make sure all comments provided on the H1020 are in Spanish. Refer to Form H1020 instructions for translation of common pending phrases.

- Form TF0001, Notice of Case Action
  - If benefits were approved, the notice informs the person of:
    - the date benefits begin or Medicaid effective date;
    - the amount of benefits;
    - the length of certification for Supplemental Nutrition Assistance Program (SNAP) EDGs; and
    - the remaining federal and state time limit months for Temporary Assistance for Needy Families (TANF), if applicable;
  - If benefits were denied, terminated or reduced, the notice informs the person:
    - the reason for the denied application, denied EDG or reduced benefits;
    - that a protective payee is required for TANF;
    - the effective date of the action;
    - the person's right to appeal;
    - the address and phone number of free legal services available in the area; and
    - that staff used a credit report resulting in less benefits than the person would have received.

The credit report information is only included on the TF0001 if applicable to the case action. If an application is denied because a person failed to keep an appointment or provide information, inform the person through the notice of what they must do to reuse the application.

Notes:

- Eligibility for multiple programs is determined independently. Do not deny an application for one program based solely on the denial of other programs unless the household fails to meet the eligibility requirements.
- When the continuous eligibility period ends, staff must retest the individual's eligibility for all appropriate Medicaid or Medicare Savings Program (MSP) and transfer coverage if eligible without requiring a new application.

Related Policy

Reuse of an Application Form After Denial, B-111
Denied for Missed Appointments, B-122.3.1
Denied for Failure to Provide Information/Verification, B-122.3.2

A–2311 General Information for Denials and Terminations

Revision 26-1; Effective Jan 1, 2026

All Programs

Denials and terminations are different types of adverse case actions.

- A denial refers to a determination of ineligibility for a person not currently receiving benefits. A denial action may occur when processing an application or a request for a new type of benefit program.
- A termination refers to a determination of ineligibility for ongoing benefits. A termination action may occur when a person no longer meets the program requirements during the certification period or when processing a redetermination based on changes in circumstances.

Note: Unless otherwise specified, the following policy applies to denials and terminations.

Procedural Denials

A procedural denial occurs when a person fails to provide all the information needed to determine eligibility. Examples of procedural denial reasons on Form TF0001, Notice of Case Action, include recipients who were sent forms to renew benefits but failed to return them by the due date. The person failed to provide the missing information by the due date.

Non-Procedural Denials

A non-procedural denial occurs when a person is not eligible for benefits based on the information provided. They do not meet one or more specific financial or non-financial eligibility requirements, and there are no exceptions that would make them eligible. Examples of non-procedural denial reasons on the Form TF0001 notice include:

- The income a person gets is more than allowed for this program. Applicant did not provide proof showing that they live in Texas.
- Applicant has not verified they are either a citizen or non-citizen who qualifies to receive benefits.

Medicaid Eligibility on All Bases

HHSC must determine if an applicant or recipient is eligible for any other type of medical benefit before determining ineligibility. Determine the person's eligibility for both Modified Adjusted Gross Income (MAGI) and non-MAGI types of assistance (TOAs).

If the applicant is eligible for another type of medical benefit, transfer them to the new TOA without requiring a new application. Only send Form H1020, Request for Information or Action, to request the information or verification needed if more information is needed to determine eligibility for other TOAs. Do not request a new application or verification of information available through electronic data sources.

Examples:

- A person submits a Form H1200 to apply for Medicaid for their minor child. Staff process the Form H1200 application, and TIERS cascades to a Children's Medicaid (CMA) EDG. Staff should review the Children's Medicaid EDG for accuracy and request any other information necessary to complete the CMA eligibility determination, without requiring the person to complete a Form H1010 or other acceptable TW application.
- An elderly person submits a Form H1010 to apply for Medicaid. Staff process the form H1010 application and TIERS cascades to a Medicaid Savings Program (MSP) EDG. Staff should review the MSP EDG for accuracy and request additional information necessary to complete the MSP eligibility determination, without requiring the person to complete a form H 1200 or other acceptable application.

Note: Form H1010 does not capture resources. When a Form H1010 is used to determine eligibility for MEPD programs, submit a request for the Asset Verification System (AVS) and obtain consent to explore resources.

Related Policy

Notice to Applicants, A-2310
Denial of an Application, A-2341
Denial at Redetermination, A-2342

A-2320, Eligibility Dates and Benefit Amounts

Body

Revision 08-1; Effective January 1, 2008

A—2321 Date Eligibility Begins

Revision 22-3; Effective July 1, 2022

TANF

TANF financial eligibility begins the earlier of the:

- certification date; or
- 30th day after the file date.

The certification date is the date staff dispose the TANF EDG. An applicant must receive benefits for the month that falls within 30 days of the file date, unless benefits prorate to less than $10.

Timeliness standards are the same for one-time payments. Proration does not apply to one-time payments.

The following examples show possible beginning dates for eligibility:

Example 1: A family applies on April 9. The certification date is April 21. Benefits are prorated from April 21.

Example 2: A family applies on April 30. The certification date is May 29, and because of proration, benefits for May are less than $10. The grant effective date is June 1.

Example 3: A family applies on April 9, but there is a delay in certification until May 15. Benefits are prorated from May 9 (30th day from the file date).

Related Policy

OTTANF, A-2411
One-Time TANF for Relatives, A-2412

SNAP

SNAP eligibility begins on the day HHSC receives a valid application, unless:

- the application is received outside of business hours, such as after hours, weekends or holidays. In these instances, SNAP eligibility begins on the next business day;
- benefits prorate to less than $10;
- the household already received benefits that month; or
- the household is not eligible for the month of application but eligible for ongoing months.

Medicaid Programs

See related policy for dates Medicaid eligibility begins.

Related Policy

Regular Medicaid Coverage, A-820
Medicaid Coverage for the Months Prior to the Month of Application, A-830

A—2322 Benefits

Revision 26-2; Effective April 1, 2026

TANF

Staff must:

- base the benefit amount on household size and net income;
- issue benefits for less than $10 only for:
  - supplemental payments; and
  - payments made after recoupment is processed;
- issue One-Time TANF (OTTANF) benefits for $1,000 to eligible households, regardless of household size or income; and
- issue One-Time TANF for Relatives payments of $1,000 to eligible households, regardless of the household size or income.

SNAP

Staff must:

- Base the household allotment on household size and net income. **Exception**: Different rules apply to SNAP Combined Application Project (SNAP-CAP) participants.
- Not issue an initial month's prorated benefits for less than $10.
- Deny the EDG if net income results in zero allotment for the initial and ongoing months.
- Issue a combined allotment when:
  - benefits are prorated;
  - the household is eligible for the application month and following month; and
    - the application file date is after the 15th of the month; or
    - the redetermination file date is after the certification period between Day 16 through Day 30.

Related Policy

Combined Allotments, A-150
Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP), B-475

A—2323 Proration

Revision 22-3; Effective July 1, 2022

TANF and SNAP

Do not issue prorated benefits of less than $10.

TANF

To calculate the prorated amount:

- determine the household's **whole** monthly benefit based on household size and net income;
- determine the earlier of the certification date or the 30th day after the file date; and
- follow additional instructions in the related policy section which describes how to prorate TANF grants.

Note: Do not prorate OTTANF or One-Time TANF for Relatives payments.

Related Policy

How to Prorate TANF Grants, C-112

SNAP

Base proration on the number of days between the file date and the end of the month. To calculate the prorated amount, determine the:

- household's **whole** monthly benefit based on household size and net income; and
- **prorated** allotment from the Proration Multiplier Chart table using the whole monthly allotment and date of application.

Note: Never prorate benefits for any month after the application month.

To calculate prorations over $300:

1. Subtract the date of application from 31.
2. Multiply the difference by the amount of the whole monthly allotment.
3. Divide that amount by 30.
4. Drop all cents.

If the date of application is the 30th or 31st, divide the whole allotment by 30.

Example: A household applies June 17. The household's whole monthly allotment is $395.

1. 31 - 17 = 14
2. $395 × 14 = $5,530
3. $5,530 ÷ 30 = $184.33
4. Round to $184. The household's prorated allotment for June is $184.

Do not prorate benefits if the household includes a member who meets both of the following criteria:

- is a seasonal or migrant farm worker (in or out of the workstream); and

- was certified for SNAP, in Texas or another state, the month before the household applied.

Related Policy

Prorated SNAP Allotments by Application Date, C-1432

A—2324 Length of Certification

Revision 25-1; Effective Jan. 1, 2025

TANF

TANF does not have a certification period. The EDG remains open until denied.

The eligibility determination system calculates the TANF periodic review due date from the date staff dispose the EDG as follows:

- Applications:
  - 11 months for payee EDGs with income of less than $3; or
  - five months for other EDGs.
- Reviews:
  - 12 months for payee cases with income of less than $3; or
  - six months for other cases.

One-Time Payments

OTTANF EDGs are not subject to periodic reviews. Applicants must reapply for subsequent TANF benefits after the ineligibility period. One-Time TANF for Relatives EDGs do not require further action.

Related Policy

One Time Payments, A-2400

SNAP

Non-Public Assistance (NPA) Households

Assign households the longest certification period possible based on their eligibility and the predictability of their circumstances, per the following table:

If the household	then certify the household for
meets the streamlined reporting (SR) criteria,	six months. **Exception**: Certify SNAP for four or five months, if necessary, so the new SNAP certification period ends one month before the end of the Children's Medicaid certification period. This allows state office to mail only one redetermination packet for both programs.
consists entirely of unemployable or elderly people with stable circumstances and the household does not meet the SR criteria,	six to 12 months. **Example:** Households whose members receive Retirement, Survivors and Disability Insurance (RSDI), Supplemental Security Income (SSI), retirement pensions or disability payments may be certified up to 12 months if other household circumstances are expected to remain stable. **Exception:** Texas Simplified Application Project (TSAP) and SNAP-Combined Application Project (SNAP-CAP) participants receive a 36-month certification period.
does not meet the SR criteria and circumstances are unstable. This includes households with an able-bodied adult without dependents (ABAWD),	three to six months.
is likely to become ineligible in the next two months due to an expected change and the household does not meet the SR criteria,	one or two months.

If the household	then certify the household for
	Example: The household does not meet SR criteria and the person indicates during the interview that someone in the household will start a new job, begin receiving unemployment benefits or move out of, or into, the household. **Exception:** If the household is certified for one or two months and the certification occurs **after** the 15th day in the last month of certification, extend the certification to the following month, unless the household is ineligible based on a change known at certification.

Notes:

- If a household meets the SR criteria, assign a six-month certification period. This includes households with self-employment income.
- Staff must give the person Form H1010, Texas Works Application for Assistance — Your Texas Benefits (PDF), and Form H1830-R, Texas Works Renewal Notice (PDF), at recertification when assigning a:
  - one- or two-month certification period; or
  - three-month certification period and the case is certified after cutoff in the first benefit month.

Related Policy

Streamlined Reporting Households, A-2350

Public Assistance (PA) Households

Most SNAP EDGs with associated TANF EDGs meet the SR criteria.

For non-SR households, assign a certification period that meets the requirements listed above for non-PA households and corresponds to the redetermination due date of the associated TANF EDG.

For SR households, assign a six-month certification period whether or not the certification period corresponds to the redetermination due date of the associated TANF EDG.

TP 08

TP 08 has a 12-month non-continuous eligibility certification period. Calculate the estimated eligibility end date as follows:

- applications — application month plus 11 months; and
- redeterminations — 12 months from the last review date.

TP 43, TP 44 and TP 48

The certification period for a child is the earliest of:

- 12 months; or
- through the month of the child's 19th birthday.

These Types of Assistance (TOAs) have a 12-month continuous eligibility (CE) certification period. Calculate the estimated eligibility end date as follows:

- applications — application month plus 11 months; and
- redeterminations — 12 months from the last review date.

Emergency Medicaid

Emergency Medicaid ends either the end date of the emergency condition or the last day of the application month, whichever is earlier.

Note: Pregnant women certified for Emergency Medicaid receive coverage through the pregnancy and 12-month postpartum period, if applicable.

Children under 19 certified for Emergency Medicaid receive coverage for a continuous 12-month certification period.

During this time, only services needed for an emergency or life-threatening situations are covered. Services provided after the emergency condition becomes stable are not covered.

TP 40

The end date is the last day of the 12th month following the expected delivery date. Review Medicaid termination policy for information on pregnancies that terminate early or late.

Note: A child under 19 determined eligible and certified for TP 40 will receive continuous eligibility (CE) through her pregnancy and 12-month postpartum period regardless if the child turns 19 before the end of her postpartum period.

Related Policy

Medicaid Termination, A-825
What to Report, B-621
Actions on Changes, B-631

TP 45

The eligibility determination system calculates an end date that is 12 months from the child's birth date. A newborn is continuously eligible for TP 45 through the month of the child's first birthday, if the child lives in Texas.

A-2330, Setting Special Reviews

Body

Revision 24-3; Effective July 1, 2024

TANF and Medical Programs

Set a special review when the household:

- anticipates a change affecting eligibility before the next redetermination;
- has questionable circumstances; or
- includes a pregnant household member whose baby is expected before the next redetermination. Schedule the special review on the first day of the month after her baby is due.

SNAP

For streamlined reporting (SR) households designated as SR 1 or SR 2, set a special review when the household:

- anticipates a change affecting eligibility before the next redetermination, including if they anticipate an increase in income over 130 percent of the Federal Poverty Level (FPL) for the household's size; or
- includes a member who does not meet the ABAWD work requirement. Set a special review for the month before the end of the ABAWD federal time limit (FTL) to disqualify the ABAWD or deny the EDG. Do not set a special review if meeting the work requirement.

For non-streamlined reporting households designated as SR 3, set a special review when the household anticipates a change affecting their eligibility determination.

Related Policy

Qualified Alien Status Eligibility Charts, A-340
ABAWD Work Requirement, A-1940
After the Three Months of Time-Limited SNAP Eligibility, A-1951
Streamlined Reporting Households, A-2350
What to Report, B-621

A—2330.1 Special Reviews for Known Changes

Revision 15-4; Effective October 1, 2015

SNAP

A known change is a change that the household reasonably anticipates will occur during the certification period.

Example: The individual has been employed in the past by the school district and will return to work at that job three months into the certification period.

Advisors must contact the household to confirm that a change occurred. If the household confirms that a change occurred, policy in B-600, Changes, applies. If the household confirms that no change occurred, the advisor must document in Case Comments the household's

explanation to complete the special review.

If the advisor requests verification of the change on Form H1020, Request for Information or Action, Request for Information or Action, but the individual fails to respond, the advisor must consider the case situation questionable and follow procedures in B-635, Shortening Certification Periods as a Result of a Change, to shorten the certification period. **Exception:** Advisors must not shorten the certification period for SNAP SR households.

A—2330.2 Special Reviews for Questionable Changes

Revision 15-4; Effective October 1, 2015

SNAP

A questionable change is a change the household thinks may happen during the certification period or that the advisor expects to happen because the household's situation is unstable.

Example 1: The individual is unemployed at the time of the interview and is looking for work but does not have a definite job offer.

Example 2: The household expenses exceed income, and the individual cannot explain future management.

Advisors must contact the household to determine whether a change occurred. If the household confirms that a change occurred, the advisor follows policy in B-600, Changes. If the household confirms that no change occurred, the advisor documents the contact in Case Comments and the household's explanation to complete the special review.

Note: Advisors must not set a special review due to questionable changes for SNAP SR households.

Related Policy

Setting Special Reviews, A-2330
Streamlined Reporting Households, A-2350

A-2340, Adverse Action

Body

Revision 13-2; Effective April 1, 2013

All Programs

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations households may continue benefits pending an appeal.

Related Policy

Fair Hearings, B-1000

A-2341 Denial of an Application

Revision 25-4; Effective Oct. 1, 2025

All Programs

Staff must provide the applicant with Form TF0001, Notice of Case Action, stating the reason for the denial. Staff must follow the policy for processing time frames. Denials are effective immediately.

Note: Staff determine eligibility for multiple programs independently of each other. They should not deny an application for one program based solely on the denial of other programs unless the household fails to meet the eligibility requirements.

Medical Programs

The eligibility system automatically sends applicants determined ineligible for Medicaid and the Children's Health Insurance Program (CHIP) at application to the Marketplace for an eligibility determination for federal health care coverage programs.

To qualify for the federal health care coverage programs, all applicants must first be determined ineligible for Medicaid and CHIP. Staff must test if an applicant is eligible for all Medical Programs. The Texas Works Medical Programs Hierarchy does this automatically for all

applicants at application.

Notes:

- Staff must follow a manual process when retesting eligibility for a minor parent aging out of TP 44, a pregnant woman from TP 40 at the end of the certification period, or a recipient at the end of the Transitional Medicaid certification period, as explained in retesting eligibility policy.
- Pregnant woman whose TP 40 coverage terminates before the end of their original certification period may be eligible for automatic retesting of eligibility for all Medical Programs as explained in Medicaid termination policy.
- When the continuous eligibility period ends, staff must retest the recipient's eligibility for all appropriate Medicaid and transfer coverage, if eligible, without requiring a new application.

Related Policy

General Information for Denials and Terminations, A116.1
Medical Programs Hierarchy, A-132.1
Medicaid Termination, A-825
Retesting Eligibility, A-2342.1
Processing Time Frames, B-100

A-2342 Denial at Redetermination

Revision 26-2; Effective April 1, 2026

TANF

Process TANF EDGs found ineligible at review following adverse action procedures.

SNAP

Staff provide the household with Form TF0001, Notice of Case Action, stating the reason for denial.

Timely Redeterminations — If a household renews by the 15th of the last month of their certification period and is determined ineligible, staff must use redetermination policy and procedures, to deny the EDG.

Untimely Redeterminations — If a household renews after the 15th of the last month of their certification period and is determined ineligible, staff must use the application policy and procedures to deny the EDG.

Medical Programs

The eligibility system automatically sends applicants determined ineligible for Medicaid and CHIP at redetermination to the Marketplace for an eligibility determination for federal health care coverage programs.

To qualify for federal health care coverage programs, all individuals must first be determined ineligible for Medicaid and CHIP. Staff must test if an applicant is eligible for all medical programs. The Texas Works Medical Programs Hierarchy does this automatically for all applicants at redetermination.

Notes:

- Staff must follow a manual process when retesting eligibility for a minor parent aging out of TP 44, a pregnant woman on TP 40 at the end of the certification period, or a recipient at the end of the Transitional Medicaid certification period, as explained in retesting eligibility policy.
- Pregnant women whose TP 40 coverage terminates before the end of their original certification period may be eligible for automatic retesting of eligibility for all Medical Programs as explained in Medicaid termination policy.
- When the continuous eligibility period ends, staff must retest the recipient's eligibility for all appropriate Medicaid and transfer coverage, if eligible without requiring a new application.

TP 08

Staff must determine if the person is eligible for TP 07, Earnings Transitional, or TP 20, Alimony/Spousal Support Transitional, in the denial effective month. Staff provide TP 07 or TP 20 instead of denying the EDG if the person is found eligible.

TP 43, TP 44 and TP 48

Staff must process a denial if the household fails to provide pending verification by the 30th day from the file date or by cutoff in the last benefit month of certification, whichever is later. Staff do not provide 13 days advance notice before denying the EDG.

Related Policy

General Information for Denials and Terminations, A116.1
Medical Programs Hierarchy, A-132.1
Medicaid Termination, A-825
Transitional Medicaid Coverage, A-841
TP 20 Alimony/Spousal Support Transitional Medicaid Coverage, A-850
Retesting Eligibility, A-2342.1
Applications, B-110
Redeterminations, B-120

A-2342.1 Retesting Eligibility

Revision 25-4; Effective Oct. 1, 2025

TP 44, TP 40, TP 07 and TP 20

Staff must retest the following applicants' potential eligibility for other medical programs by manually running the Texas Works Medical Program Hierarchy explained in Medical Programs Hierarchy, starting policy, Step 1 in the following hierarchy:

- minor parents aging out of TP 44, children 6-18;
- recipients on TP 40, pregnant women, once their certification period ends; and
- recipients terminated from TP 07 or TP 20, transitional Medicaid programs.

All other recipients flow through the hierarchy to either the next available program or referred to the Marketplace if determined ineligible for all other medical programs. For example:

- A child aging out of TP 48 is automatically tested for TP 44.
- A non-parent child determined ineligible because of aging out of TP 44 is referred to the Marketplace.

The system does not terminate eligibility for the people listed above at the end of the certification period. Staff act to review the person's eligibility and re-run the hierarchy to determine potential eligibility for other programs. Staff must use the first day of the last month of the current certification period as the file date. Staff should process the EDGs like a redetermination, without requiring a renewal form. Except in the case of TP 40, where there may be an application, staff process the EDG as they do redeterminations with renewal forms. Staff must verify information the way it is done in the redetermination process.

Do not re-evaluate the remaining people in the recipient's household composition for eligibility during a continuous eligibility period. Changes to household composition such as a minor parent aging out, the end of a pregnancy, or the termination of Transitional Medicaid coverage, must be addressed once the person is no longer eligible for a program with 12-month continuous eligibility. This includes Children's Medicaid (TP 44), Pregnant Women (TP 40), or Transitional Medicaid programs (TP 07 and TP 20). Once the continuous eligibility period ends, staff must re-evaluate the recipient's eligibility for all appropriate Medicaid or MSP and transfer coverage, if eligible, without requiring a new application.

Note: An interview is required when testing for TP 08.

Related Policy

General Information for Denials and Terminations, A-116.1
Medical Programs Hierarchy, A-132.1

A-2343 Advance Notice

Revision 15-4; Effective October 1, 2015

All Programs

After approval, advisors give households advance notice of adverse actions to deny, terminate, lower, or restrict existing benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

A-2343.1 How to Take Adverse Action if Advance Notice Is Required

Revision 20-4; Effective October 1, 2020

All Programs

TIERS provides 13 days advance notice to the household after informing them of a denial or termination of ongoing benefits using Form TF0001, Notice of Case Action. The day Form TF0001 is sent is day zero of the adverse action period.

If the 13-day advance notice period:

- does not expire until after the last day of the month (regardless of whether the 13th day is a business day), the household is eligible for the same level of benefits the month after the notice was sent.
- expires between cutoff and the end of the month, the reduction or denial is effective the following month. **Note:** Do not deny TP 40 EDGs when taking adverse action for failure to provide postponed verification.

TANF

Provide 13 days advance notice to the household using Form TF0001 before taking action to:

- establish a protective payee; or
- continue a protective payee because of mismanagement.

To establish a protective payee because the person mismanaged TANF benefits, follow advance notice policy above.

At complete redetermination, re-evaluate the situation to determine whether the protective payee should continue. If the decision is to continue, notify the person by sending Form TF0001.

If the person appeals this decision, issue TANF benefits to a protective payee until the hearing is completed.

Medical Programs

A person applying for Medicaid who declares U.S. citizenship or an eligible alien status, but for whom verification is unavailable, receives a 95-day period of reasonable opportunity to provide verification of citizenship or alien status. The reasonable opportunity period expires on the 95th day from when the TF0001 was generated. Deny the person and provide 30 days advance notice of adverse action to the household if they do not provide verification of citizenship or alien status.

Related Policy

Reasonable Opportunity, A-351.1

A-2344 Adverse Actions Not Requiring Advance Notice

Revision 13-2; Effective April 1, 2013

A-2344.1 Form TF0001 Required (Adequate Notice)

Revision 26-2; Effective April 1, 2026

All Programs

The following situations require that the household is given adequate notice:

- The post office returns Texas Health and Human Services Commission (HHSC) mail with no forwarding address because the person's location is unknown.
- The head of the household, authorized representative or other responsible household member:
  - verbally volunteers to withdraw in HHSC staff’s presence, either in the office or by phone; or
  - gives HHSC a written, signed report of change, and staff determine the:
    - exact amount of the reduced benefits; or
    - that the household is ineligible.

Note: This includes situations when HHSC receives Form H1028, Employment Verification, signed by the household and completed by the employer.

- The household reports in advance they will move out of state.
- Employment and Training (E&T) noncooperation is received in the last benefit month.

Related Policy

How to Report, B-623
Sending Notice of Failure to Cooperate, A-1845.1

TANF and Medical Programs

Send Form TF0001, Notice of Case Action, without advance notice in the following situations:

- Staff deny or reduce benefits when a person reaches the maximum age described in A-220, TANF, and A-240, Medical Programs.
- Staff confirm the person's or payee's death when no relative is available to serve as new payee.
- Staff reduce the grant or deny a Medical Program recipient because the person received a new TANF or SSI grant.
- Staff impose a full-family sanction because of noncooperation with one or more Personal Responsibility Agreement (PRA) requirements.
- Staff deny a TP 08 recipient because of noncooperation with medical support.
- The person was admitted or committed to an institution and no longer qualifies for TANF or Medical Programs benefits.
- The person was placed in skilled nursing care or intermediate care.
- Staff deny a TANF or TANF-State Program (SP) EDG because the caretaker or second parent received their lifetime limit of 60 months.
- HHSC verifies a person is certified for SSI or TANF in another state.
- A TANF or medical program child is removed from the home by court order or voluntarily placed in foster care by the legal guardian.

Related Policy

The Texas Works Message, A-1527

SNAP

Send Form TF0001 without advance notice in the following situations:

- The household fails to provide verification postponed during expedited services or provides postponed verification that results in lowered or denied benefits.
- Staff discover information an expedited household failed to report. The information:
- exists on the interview date;
    - results in lowered or denied benefits; and
    - is discovered between the time the application is approved with postponed verification and on or before the 30th day.
- A drug and alcohol treatment or group living arrangement facility loses its status as authorized representative or loses its certification.
- Centralized Benefit Services (CBS) contacts field staff to deny the SNAP EDG to certify the SNAP Combined Application Project (SNAP-CAP) EDG. **Note:** If the SNAP-CAP applicant is certified for SNAP with other household members, allow advance notice of adverse action before removing the person from the existing SNAP EDG.

Related Policy

General Policy, A-710

A-2344.2 No Form TF0001 Required

Revision 15-4; Effective October 1, 2015

All Programs

Form TF0001, Notice of Case Action, is not required in the following situations:

- the state or federal government initiates mass changes that affect the entire caseload or significant portions of the caseload, such as the annual Social Security cost-of-living adjustment.
- the household moves out of state and reports it afterward.
- the household gives HHSC a written, signed request to voluntarily withdraw.

TANF

Form TF0001 is not required when child support collected by the Office of the Attorney General exceeded the amount of the grant plus the $75 disregard. In these cases, state office sends Form H1718, Notice of Benefit Denial, to the individual.

SNAP

Form TF0001 is not required in the following situations:

- All members of a household have died.
- The individual's allotment changes from month to month during the certification period because of changes expected at the time of certification. In this situation, inform the individual on Form TF0001 at the time of certification that the household's allotment will vary.
- The individual applied for TANF and SNAP at the same time and received SNAP while waiting for approval of the TANF grant.

A-2350, Streamlined Reporting Households

Body

Revision 24-3; Effective July 1, 2024

SNAP

Streamlined reporting minimizes the information that households must report during the certification period to maintain their benefit level and eligibility. Households are subject to streamlined reporting criteria as follows.

SR 1 Households

Households with reported income below 130 percent of the federal poverty level (FPL) are designated as SR 1 and are subject to streamlined reporting criteria.

SR 2 Households

Households with reported income above the 130 percent FPL but below 165 percent of the FPL are designated as SR 2 and are subject to streamlined reporting criteria.

SR 3 Households

Households that do not meet the streamlined reporting criteria are designated as SR 3 and are **not** subject to streamlined reporting criteria. These households:

- are aware at application or redetermination of a change that will make them ineligible within the next six months. **Note:** Do not consider an anticipated change in household composition or residency as a known change until it actually occurs;
- contain at least one non-exempt ABAWD who is not meeting the ABAWD work requirement; or
- are certified for four months or less.

At application and recertification, use the following table to determine the household's SR designation.

Step	Question	If yes,	If no,
1	Is the household aware of a change that will make them ineligible for SNAP in the next six months?	designate the household as SR 3.	continue to step 2.
2	Does the household contain at least one non-exempt ABAWD who is not meeting the work requirement?	designate the household as SR 3.	continue to step 3.
3	Will the household be assigned a certification period of four months or less?	designate the household as SR 3.	continue to step 4.
4	Does the household have income below 130 percent of the FPL?	designate the household as SR 1.	designate the household as SR 2.

The household retains its SR designation throughout the certification period. Do not remove the SR designation at incomplete reviews. For example, when a household designated as SR 1 or SR 2 reports a change where an ABAWD household member no longer meets the ABAWD work requirement, the household remains as SR 1 or SR 2 through the end of the certification period. Designate the household as SR 3 at their next redetermination.

Related Policy

ABAWD Work Requirement, A-1940
Length of Certification, A-2324
Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP), B-475
Texas Simplified Application Project (TSAP), B-477
What to Report, B-621

A—2351 Disqualified Members

Revision 16-2; Effective April 1, 2016

SNAP

Advisors must extend SR policy to households containing disqualified members. In a household containing all elderly and/or members with a disability, the household can meet the SR criteria, even if the disqualified member is the only person with earnings.

Advisors do not consider a disqualified member an ABAWD for purposes of determining SR status, even if the member is disqualified due to exhausting the individual's SNAP ABAWD time limits. Advisors consider only eligible household members for this purpose.

A-2360, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

All Programs

Documentation must be sufficient to support the advisor's decision for denying or terminating the EDG. Refer to C-940, Documentation, for requirements related to adverse action decisions.

If not obvious, advisors must document that:

- adequate notice was allowed according to policy in A-2344.1, Form TF0001 Required (Adequate Notice); or
- Form TF001, Notice of Case Action, was not required according to policy in A-2344.2, No Form TF0001 Required.

TANF and Medical Programs except Emergency Medicaid

Advisors must thoroughly document the reason for any special review and explain any information needed and the acceptable verification required to clear the review.

SNAP

Advisors must document the:

- reason for extending a certification period;
- reason for modifying the designators or override tab; and
- reason for setting a special review, thoroughly explaining why the special review was set, any information needed, and the acceptable verification required to clear the review.

Related Policy

Setting Special Reviews, A-2330
Documentation, C-940
The Texas Works Documentation Guide

A-2400, One Time Payments

A-2410, General Policy

Body

Revision 13-2; Effective April 1, 2013

A—2411 OTTANF

Revision 17-3; Effective July 1, 2017

TANF

One Time Temporary Assistance for Needy Families (OTTANF) provides $1,000 cash assistance for families in crisis. The intent of the OTTANF payment is to help solve a short-term crisis and divert households from ongoing TANF benefits. These families must

- meet all TANF eligibility requirements; and
- not currently receive TANF.
  Note: Households who are active on Type Programs (TP) 07, 20 or 37 may apply for OTTANF.

A household has an option of receiving TANF or OTTANF if it meets one of four crisis criteria. Households who choose this option are not eligible to receive TANF, TANF-SP, or OTTANF payments for 12 months.

The following type programs (TPs) identify OTTANF Eligibility Determination Groups (EDGs):

- **TP 71** – for a one parent household; and
- **TP 72** – for a two parent household based on incapacity or TANF-SP.

The following participation statutes are required for an OTTANF EDG:

- Eligible Adult – caretaker in an OTTANF household;
- Eligible Adult – second parent in an OTTANF household;
- Eligible Child – an eligible child in an OTTANF household; and
- Other Child – an SSI child

Related Policy

Certifying Children on Non-Parent Caretaker EDGs, A-223
Form H1072, One Time Temporary Assistance for Needy Families Acknowledgement

A—2412 One-Time TANF for Relatives

Revision 22-3; Effective July 1, 2022

TANF

Provide a $1,000 supplemental payment to certain relatives caring for a related dependent child or children in the home, if the relative:

- is 25 or older. This includes those who turn 25 in the month the eligibility determination is made and couples in which one person is 25 or older (regardless of which one is the caretaker or payee);
- is a grandparent, aunt, uncle, brother or sister of the child or children and meets the TANF relationship requirement in the TANF and medical programs relationship chart. This includes to the degree of great or great-great for grandparents, aunts and uncles;
- is the caretaker or payee (or spouse of the caretaker or payee) of a TANF-certified child, including households who receive OTTANF;
- has a family gross income less than or equal to 200% of the Federal Poverty Level (FPL); and
- has resources less than or equal to the TANF resource limit of $1,000.

Note: A relative who is a payee is only required to meet the eligibility requirements noted above to qualify for the supplement. To be certified as a TANF caretaker, the relative must meet all TANF requirements.

No matter how many children are in the certified group, the relative receives a once in a lifetime single payment of $1,000. Once a relative receives a One-Time TANF for Relatives payment, the relative is not eligible to receive the payment again for other children who move into the home at a later time. Additionally, another relative cannot receive the payment for a child who has already received the payment.

The related dependent child must currently receive TANF or be newly certified for TANF (including open and close certifications).

Notes:

- A relative does not qualify based solely on a related child in the home who receives SSI.
- One-Time TANF for Relatives was previously known as the TANF Grandparent Payment and was limited to grandparents. If the relative or a child was in a certified group that received the Grandparent Payment, they are not eligible for One-Time TANF for Relatives.
- The child's cousins, nieces and nephews are not included in the list of potentially eligible relatives that can receive the One-Time TANF for Relatives payment.

Related Policy

Certifying Children on Non-Parent Caretaker EDGs, A-223
Limits, A-1220
Time Frames for Qualifying for Restored Benefits, B-820
Relationship Charts, C-1440

A-2420, Eligibility Requirements

Body

Revision 05-5; Effective October 1, 2005

A—2421 OTTANF Requirements

Revision 13-2; Effective April 1, 2013

TANF

OTTANF households must:

- be eligible for TANF and eligible to receive a TANF grant of $10 or more in any month from the application or through the certification month;
- not include a member who is disqualified or has an open PRA penalty; and
- meet one of four crisis criteria listed in A-2440, Determining Crisis Criteria (OTTANF).

Note: The household does not have to be eligible for ongoing TANF to qualify for OTTANF.

If the household opts for OTTANF but fails to provide additional information needed for OTTANF, certify the application for TANF or TANF-SP without recontacting the individual.

A—2421.1 Citizenship

Revision 05-5; Effective October 1, 2005

TANF

All adult members of the household and at least one child must meet TANF citizenship requirements to be eligible for OTTANF. A child who is an ineligible alien is a non-household member.

A—2421.2 Deprivation Based on Incapacity

Revision 05-5; Effective October 1, 2005

TANF

If a household claims incapacity, follow the procedures in A-1050, Deprivation Based on Incapacity, before offering OTTANF.

A—2421.3 Child Support

Revision 13-2; Effective April 1, 2013

TANF

Advisors must gather child support information as required for TANF EDGs. If the advisor processes the application as an OTTANF EDG, TIERS will not send the information to the Office of the Attorney General (OAG).

A—2421.4 Employment Services

Revision 05-3; Effective July 1, 2005

TANF

Required members must attend a workforce orientation before being offered OTTANF. Other employment services requirements do not apply to OTTANF.

A—2421.5 Personal Responsibility Agreement (PRA)

Revision 05-3; Effective July 1, 2005

TANF

Households must meet all TANF requirements, including the requirement to sign the PRA.

OTTANF applicants with an open PRA penalty must demonstrate cooperation to be eligible for OTTANF. See A-2100, Personal Responsibility Agreement.

A—2422 Requirements for One-Time TANF for Relatives

Revision 22-3; Effective July 1, 2022

A—2422.1 Determining the Budget and Certified Group

Revision 23-1; Effective Jan. 1, 2023

TANF

Determining the Budget Group

To determine income eligibility, include:

- the relative and the relative's spouse if there is one;
- the related dependent children for whom the relative is applying; and
- any children of the relative, biological or adopted, who meet the TANF age and relationship requirement and for whom the relative could apply for TANF.

People included in the budget group may be disqualified or have a financial penalty.

Example: The household consists of Mr. and Mrs. Garza who are caring for two nephews, Chris, 2, and Oscar, 4. Mr. and Mrs. Garza have two children, Rick, 16, and Robert, 19. Rick and Robert live at home. Mrs. Garza is an ineligible alien and is the payee on the TANF EDGs for her two nephews.

To determine income and resource eligibility for One-Time TANF for Relatives, include the following members in the budget group: Mr. and Mrs. Garza, both nephews and Rick. Do not include Robert because he does not meet the age requirement.

Determining the Certified Group

The certified group consists of the TANF EDG caretaker or payee relative, the spouse of the relative, if applicable, and the related dependent children for whom the relative is applying.

Example: The following is the certified group for the Garza family noted in the example: Mr. and Mrs. Garza and both nephews. Rick and Robert are not included in the certified group.

A—2422.2 Income and Resource Guidelines

Revision 22-3; Effective July 1, 2022

TANF

Count the income and resources of all members of the budget group. Compare the household's gross income to 200 percent of the FPL. Do not allow any income deductions.

Compare the budget group's resources to the TANF resource limit of $1,000.

Use TANF income and resource guidelines to determine countable and exempt income and resources.

Do not count the $1,000 One-Time TANF for Relatives payment as income in the Supplemental Nutrition Assistance Program (SNAP), TANF or Medicaid EDG. Consider it a resource of the TANF certified child(ren), and therefore exempt from SNAP resources.

The supplement counts as a TANF benefit for purposes of determining the amount of child support owed to Texas.

Related Policy

Resources of TANF and SSI Recipients, A-1248

A-2430, Who Is Not Eligible

Body

Revision 05-5; Effective October 1, 2005

A—2431 Who Is Not Eligible for OTTANF

Revision 13-2; Effective April 1, 2013

TANF

Do not offer OTTANF to a household if any member:

- is disqualified;
- is an active TANF individual;
- has an open PRA noncooperation and fails to demonstrate cooperation within the allowed time period;
- does not meet citizenship requirements for TANF (see A-2421.1, Citizenship);
- is a caretaker or second parent who received OTTANF within the previous 12 months;
- is a caretaker or second parent who did not receive OTTANF in the previous 12 months but now lives with a household that received OTTANF in the previous 12 months and would have been a required member of the household; or
- is receiving Refugee Cash Assistance (RCA).

Notes:

- Consider an individual as being active in TANF if the individual applies for OTTANF during the individual's second noncooperation month.
- Do not provide OTTANF for months identified as a forfeit month because of noncooperation with the PRA.
- OTTANF applicants with an open PRA penalty must demonstrate cooperation to be eligible for OTTANF. See A-2100, Personal Responsibility Agreement.

A—2431.1 12-Month Ineligibility Period

Revision 17-3; Effective July 1, 2017

TANF

A caretaker or second parent certified for OTTANF is ineligible for TANF, TANF-SP or OTTANF for 12 months. The first month of the 12-month ineligibility period is the grant effective month. When a caretaker and/or second parent of an OTTANF EDG moves to a new household, the individual takes the 12-month ineligibility period status along with the move. Children are only ineligible for the OTTANF grant effective month.

Example 1:

Mary applies for and receives OTTANF for herself and child in December. In June, she marries a man with two children who do not receive TANF. Mary and her husband have a mutual child. The new household is not eligible for TANF or OTTANF until the following December because the ineligibility period follows the caretaker. The household can apply for medical programs.

Anyone who would have been a mandatory member of the TANF group at the time of certification is not eligible for TANF benefits during the 12-month ineligibility period.

Example 2:

Ms. King received OTTANF for herself and her two children with a grant effective date of September 2012. In December 2012, her child Ryan, who was living with his father, moves into her household. Ms. King applies for TANF for Ryan. Because Ryan would have been included in the budget group at the time of certification, he cannot receive OTTANF or TANF until September 2013.

Use the following chart to determine eligibility when minor parents move into or out of an OTTANF or TANF household.

If a minor parent ...	and moves ...	then the minor parent is ...
received OTTANF on a parent's EDG	out and applies for TANF for the minor parent and for the child,	eligible for OTTANF or TANF.
received OTTANF as a child in any household	in with a parent who receives TANF,	eligible for TANF after the OTTANF ineligible month.
received OTTANF as a caretaker	in with a parent who receives TANF,	eligible for TANF. **Note:** Contact the IEE/TIERS Technical Help Desk to address the removal of the ineligible date.
receives TANF as a caretaker	in with a parent who received OTTANF,	ineligible for TANF or OTTANF if the minor parent would have been a required member of the parent's EDG at the time OTTANF was certified.

A—2432 Who Is Not Eligible for One-Time TANF for Relatives

Revision 22-3; Effective July 1, 2022

TANF

A household is not eligible for One-Time TANF for Relatives if:

- the gross income for the household exceeds the income limit;
- the resources available to the household exceed the resource limit;
- the applicant and child do not meet the age or relationship requirements; or
- either the relative or child have already received One-Time TANF for Relatives.

One-Time TANF for Relatives was previously known as the TANF Grandparent Payment and was limited to grandparents. If the relative or a child was in a certified group that received the Grandparent Payment, they are not eligible for One-Time TANF for Relatives.

A-2440, Determining Crisis Criteria

Body

Revision 05-4; Effective August 1, 2005

TANF

In addition to meeting all TANF requirements, the household must also meet one of the following four crisis criteria.

A—2441 Crisis Criteria One (TP 71 or 72)

Revision 07-3; Effective July 1, 2007

TANF

The caretaker or second parent must have a loss of any type of employment without regard to work history or certain dollar amount in the

- two months before application,
- application month, or
- process month.

Notes:

- If the household's income terminated in the process month and exceeded the TANF recognizable needs amount, the household may be eligible for OTTANF the month after the process month.
- As long as the individual meets the criteria above and is TANF eligible, the individual may receive OTTANF regardless of the individual's current employment status.

Do not apply Crisis Criteria One if an applicant voluntarily quits a job, including self employment, without good cause.

Temporary leave without pay from a job does not constitute loss of employment.

Related Policy

Reasons for Good Cause, A-1861

A—2442 Crisis Criteria Two (TP 71)

Revision 07-3; Effective July 1, 2007

TANF

In a one-parent household, the:

- dependent child must have a loss of financial support from the legal parent or stepparent within the last 12 months before the application month or process month through death, divorce, separation or abandonment or through termination or reduction of financial support; and
- caretaker must have been employed within the 12 months before the application or process month.

Financial support, including child support, is assistance with basic living expenses like rent, utilities and food. Loss of financial support from a legal parent or stepparent must be verified.

A—2443 Crisis Criteria Three (TP 71 or 72)

Revision 13-2; Effective April 1, 2013

TANF

The caretaker or second parent graduated from a university, college, junior college or technical training school within the 12 months before the application or process month, and is unemployed or underemployed. The caretaker or second parent must:

- provide proof of degree or certificate of completion from a technical training school, junior college, college or university. This includes beauty, nursing or vocational school. The institution can be in or out of Texas;
- not currently be enrolled in an institution of higher learning; and
- have received TANF or an OTTANF benefit (in Texas) anytime in the 12 months before enrolling, or while attending a college, university, or technical training school. Attempt to verify prior receipt of TANF or OTTANF, but accept the individual's statement if TIERS records for that time are not available.

A—2444 Crisis Criteria Four (TP 71 or 72)

Revision 13-2; Effective April 1, 2013

TANF

The caretaker and/or second parent is currently employed but still meets TANF requirements and is facing a crisis situation in the

- two months before application,
- application month, or
- process month.

The crisis situations are:

- **Loss or potential loss of transportation** — The applicant is unable to get to a job. The loss of a vehicle can be because of needed repairs, lack of insurance, necessary inspection, repossession, or threat of repossession.
- **Loss or potential loss of shelter** — The household may lose shelter because of foreclosure, eviction, condemnation, or threat of any of these.
- **Medical emergency** (60 days or less) — A caretaker/second parent has a medical emergency or is needed to provide temporary care for a household member who is ill or injured. The medical emergency can be for the applicant or a household member within the TANF degree of relationship. Do not apply this policy to individuals outside the home except for members who are in the hospital. A normal pregnancy or maternity leave is not a medical emergency.

A-2450, Issuing Benefits

Body

Revision 05-4; Effective August 1, 2005

A—2451 Issuing OTTANF Benefits

Revision 13-2; Effective April 1, 2013

TANF

Use the same timeliness processing standards for OTTANF as for the TANF program. (See B-100, Processes and Processing Time Frames.)

A—2451.1 Reissuing Benefits

Revision 23-3; Effective July 1, 2023

TANF

Use Form H1008-A, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-Receipt of Warrant (PDF), for lost or stolen OTTANF warrants.

Fax Form H1008-A to HHS Accounting Operations within Fiscal Management Services at 512-487-3400. Staff may also scan and email the form to the HHS Warrant Issuance mailbox.

Write "OTTANF" across the top of the form.

When HHS Accounting Operations determines someone has cashed the warrant, HHSC eligibility staff may need to supply more information and take further action. HHS Accounting Operations contacts the HHSC eligibility staff member who submitted the Form H1008-A and may request items such as a copy of a police report filed by the TANF recipient and notarized statements from household members. See the related policy concerning cashed warrants.

Related Policy

One-Time Payment Replacements, B-342
Warrant Cashed, B-342.2

A—2451.2 Switching from OTTANF to TANF

Revision 17-3; Effective July 1, 2017

TANF

When an applicant opts for OTTANF then decides to receive TANF, use the chart below to determine how to issue benefits:

If ...	then ...
the OTTANF warrant has been issued but not cashed,	• if the applicant has received the warrant, instruct the applicant to return the warrant to HHSC. • contact the IEE/TIERS Technical Help Desk to address any issues with the removal of the ineligible dates by emailing IEE_HELP@hhsc.state.tx.us or calling 800-214-4175 (Option 1). ◦ If emailing, enter **Cancelling OTTANF Benefits When Client Was Erroneously Certified for OTTANF Instead of TANF/TANF SP** as the email subject line. ◦ If calling, tell the Help Desk representative that your issue relates to "Cancelling OTTANF benefits when client was erroneously certified for OTTANF instead of TANF/TANF SP." • cancel the OTTANF warrant using Form H1008-A, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-receipt of Warrant (PDF), and request issuance of TANF benefits for the OTTANF grant effective month using Form H1008-A. • document the reason for the switch. • record the Help Desk ticket number in **Case Comments.**
the OTTANF warrant has been cashed,	**do not** accept the $1,000 payment in the form of cash, cashier's check or money order. The applicant is not allowed to switch in this situation.

A—2451.3 Switching from TANF to OTTANF

Revision 13-2; Effective April 1, 2013

TANF

Do not allow applicants to switch from TANF to OTTANF once the TANF EDG has been certified. **Exception:** Follow procedures below only if HHSC did not explain or offer the applicant the OTTANF option.

- Contact the IEE Help Desk via email at IEE_HELP@hhsc.state.tx.us or at 800-214-4175 (Option 1).
  - If emailing, enter **Cancelling TANF Benefits When Client Was Erroneously Certified for TANF/TANF SP Instead of OTTANF** as the email subject line.
  - If calling, tell the Help Desk representative that your issue relates to "Cancelling TANF benefits when client was erroneously certified for TANF/TANF SP instead of OTTANF."
- Submit a referral to recoup the TANF/TANF SP benefits already issued.
- Withdraw TANF in the program page.
- Pull the case back into Complete Action (if appropriate).
- Record the Help Desk ticket number in **Case Comments.**

A—2452 Issuing One-Time TANF for Relatives Payments

Revision 22-3; Effective July 1, 2022

TANF

Before certification, complete inquiries in both TIERS and the retired Grandparent Payment System (GPS) to ensure certified group members have not previously received a one-time Grandparent Payment. Inquire in TIERS to ensure certified group members have not received a Grandparent Payment or a One-Time TANF for Relatives payment.

The one-time Grandparent Payment is the same benefit as the One-Time TANF for Relatives, previously limited to grandparents. Therefore, staff must complete inquiries for both types of payments before certification.

Inform recipients that they will receive the payment through the mail in the form of a warrant (check) and that the U.S. Postal Service (USPS) does not forward TANF warrants. The address HHSC has for the person and the address with the USPS must be the same.

A—2452.1 Reissuing One-Time TANF for Relatives Payments

Revision 23-3; Effective July 1, 2023

TANF

When a household reports the One-Time TANF for Relatives warrant as lost, destroyed, stolen or not received, complete Form H1084, Certification for Warrants Lost (PDF), Destroyed, Stolen or Not Received. Have the recipient sign the certification statement and send the form to HHS Accounting Operations.

When HHS Accounting Operations determines someone has cashed the warrant, HHSC eligibility staff may need to supply additional information and take further action. HHS Accounting Operations will contact the HHSC eligibility staff member who submitted the Form H1084 and may request items such as a copy of a police report filed by the TANF recipient and notarized statements from household members. See the related policy concerning cashed warrants.

Related Policy

One-Time Payment Replacements, B-342
Warrant Cashed, B-342.2

A-2460, Verification Requirements

Body

Revision 22-3; Effective July 1, 2022

TANF

For One Time Temporary Assistance for Needy Families (OTTANF) Payments:

- Verify the required members attended the workforce orientation.
- Verify the household has lost or will lose transportation due to:
  - needed repairs;
  - repossession or threat of repossession;
  - lack of insurance;
  - necessary inspection; or
  - driver license.

Verify these conditions if the loss occurred during the application month, two months prior to the application month or the process month. Verify that the household has lost or will lose shelter due to:

- foreclosure;
- eviction; or
- condemnation.

Verify these conditions if the loss occurred during the process month, application month or two months prior to the application month.

- Verify:
  - the medical emergency;
  - that the medical emergency is temporary;
  - that the member (certified or not) is within the required degree of relationship; and
  - the member lives in the home.
- Verify:
  - parental relationship; and
  - loss of financial support from the legal parent or stepparent.
- Verify:
  - proof of graduation or certificate of completion from a college, university, junior college or technical training school.
  - that the person received TANF benefits in Texas.
  - TANF benefits have been cancelled prior to certifying the OTTANF EDG.

For One-Time TANF for Relatives verify:

- the age of the relative;
- relationship;
- that the relative is a caretaker or payee (or spouse of a caretaker or payee) of a related dependent child certified for TANF, and the parent of the child is not in the home;
- that the family has gross income less than or equal to 200% of the FPL; and
- that the family resources are less than or equal to TANF resource limits.

Related Policy

Limits, A-1220
Switching from TANF to OTTANF, A-2451.3
Questionable Information, C-920
Providing Verification, C-930

A-2470, Documentation Requirements

Body

Revision 22-3; Effective July 1, 2022

TANF

For OTTANF, document:

- OTTANF verifications and an explanation of the household situation in case comments;
- the household has been informed of the one-time payment at application and whether the caretaker requested or declined the payment; and
- which of the following crisis criteria the applicant meets to qualify for OTTANF:
  - loss or potential loss of income;
  - loss of spousal support;
  - proof of graduation;
  - loss or potential loss of transportation;
  - loss or potential loss of shelter; or
  - medical emergency.

When verification is unavailable, document:

- the person's statement;
- the reason verification is unavailable; and
- efforts made to obtain verification.

For One-Time TANF for Relatives, if the relative:

- Is potentially eligible, document the household has been informed of the one-time payment at application or review and whether they requested or declined the payment.
- Requests the payment, document:
  - TIERS and GPS inquiry was completed and whether the household did or did not previously receive a Grandparent Payment or One-Time TANF for Relatives;
  - the household's income and resources; and
  - that the requesting household meets the eligible relative caretaker or payee criteria.

A-2500, State Time Limits

A-2510, General Policy

Body

Revision 13-2; Effective April 1, 2013

TANF

State time limits determine the number of months certain individuals can receive TANF benefits.

The TANF Program and TANF State Program limit caretakers and second parents to a 60-month lifetime limit. When a caretaker or second parent receives 60 months of benefits, their entire household is ineligible.

Caretakers and second parents are also subject to a state time limit of 12, 24 or 36 months of benefits based on their work history and education. Other household members may continue to receive benefits after a caretaker or second parent reaches their 12-, 24- or 36-month time limit.

The individual's education and/or recent work experience determine(s) the individual's state time limit. There are three time limits, known as "tiers." Tiers and their corresponding state time limits are:

Tier	State Time Limit
5	12 months
6	24 months
7	36 months

Note: TIERS enters Tier 8 when the advisor does not enter enough information.

All certified caretakers and second parents, including minor parents certified as caretakers and second parents, receive a state time limit tier.

State time limits apply to the TANF cash benefits received by certified caretakers and second parents who have access to Choices employment services.

After the individual is notified to participate or voluntarily participates in the Choices program, each month the individual has an open Choices case and is certified as a TANF caretaker or second parent counts toward the state time limit.

When a TANF caretaker or second parent reaches their time limit, TIERS disqualifies the individual from receiving TANF in Texas for five years. The children on the TANF EDG remain eligible.

Exception: During the five-year freeze out period, disqualified individuals who meet the criteria for a hardship exemption may receive TANF.

Individuals may continue receiving TANF Level Medicaid and transitional child care benefits during the 12 months following their last state time limit month. (See A-840, Transitional Medicaid Coverage.)

A-2520, Time Limit Tiers

Body

Revision 13-2; Effective April 1, 2013

A—2521 Initial Time Limit Tiers

Revision 13-2; Effective April 1, 2013

TANF

TIERS determines the initial time limit tier for all TANF caretakers or second parents, including those with a current employment service exemption:

- at application; and
- when adding an individual to the household.

A—2521.1 Determining the Time Limit Tier

Revision 13-2; Effective April 1, 2013

TANF

When advisors correctly identify education and work history status in the TANF TIER Level Details Logical Unit of Work (LUW), TIERS automatically determines the time limit tier for each certified caretaker and/or second parent. Accept the individual's statement of the grade completed.

TIERS prints the individual's state time limit information on TF0001, Notice of Case Action.

A—2522 Time Limit Tier Changes

Revision 13-2; Effective April 1, 2013

The time limit tier may change when:

- Choices staff determine a functional literacy level which affects the tier;
- the advisor makes an error in entering the correct education or work history level; or
- redetermining the education and/or work history level at reapplication if the individual missed one full month's benefits before the date of reapplication.

A—2522.1 Change in Time Limit Tier Because of Functional Literacy Level

Revision 13-2; Effective April 1, 2013

TANF

Choices staff determine and enter the individual's functional literacy level in the Choices automated system. This information overrides the initial time limit tier determined by the advisor when:

- the functional literacy level is lower than the individual's completed education level; and
- a change in tier allows the individual to receive additional months of TANF and Choices services.

A tier may not change to one lower than the individual's work history level.

When the Choices literacy level updates the individual’s tier level using the Choices automated interface, the advisor may not change the tier because of the education level.

A—2522.2 Change in Time Limit Tier Because of Error

Revision 13-2; Effective April 1, 2013

TANF

If an advisor initially entered incorrect information, correct the original work history months or the original education level in TIERS and select YES from the Correction drop-down menu. Do not update work history or education levels for changes that occurred since determining the initial tier.

If an advisor request State Office Data Integrity (SODI) to force change a tier from 5 or 6 to tier 7, the advisor must also request that SODI delete all months in the individual's Time Limited history that occur before the year's anniversary of the individual's Literacy Assessment Date. (See A-2532, Counting Months for Tier 7, for an example of how to determine the Literacy Assessment anniversary date.) If the individual does not have a Literacy Assessment Date, request the deletion of all months counted. **Exception:** Do not delete any months counted before the Literacy Assessment Date month in which the individual has a Choices penalty.

A—2522.3 Changes to Time Limit Tiers at Reapplication

Revision 13-2; Effective April 1, 2013

TANF

TIERS redetermines the time limit tier of a TANF caretaker or second parent at reapplication only if there has been at least one full month's break in benefits before the date of reapplication. **Note:** The individual may have more months or an equal number of months remaining in the individual’s new time limit, but would never have fewer months than the prior time limit.

A-2530, Counting TANF Months Toward State Time Limit

Body

Revision 17-3; Effective July 1, 2017

TANF

TIERS tracks the number of months counted toward an individual's state time limit. TIERS uses the Notification Effective Date (NED) and counts a month toward an individual's state time limit each month the individual:

- receives TANF;
- is certified as a caretaker or second parent; and
- has an open Choices case without Choices good cause indicated, or is sanctioned for Choices non-participation.

The advisor must:

- evaluate the accuracy of the months counted toward the individual's state time limit; and
- contact the IEE/TIERS help desk to address any issues with the individual's time limit months counted.

Notes:

- The automated procedures for counting months for Tiers 5 and 6 are different than for Tier 7.
- See A-2533, Changes to State Time Limit Months Counted, for changes to the individual's time-limited months' history.
- In minimum service Choices counties, all individuals are considered exempt from Choices participation even when the advisor codes them as M – mandatory. TIERS counts months toward the individual's time limit if the Choices case status is Open.

A—2531 Counting Months for Tiers 5 and 6

Revision 13-2; Effective April 1, 2013

TANF

For individuals in Tier 5 or 6, TIERS counts months based on the Notification Effective Date (NED).

The Choices specialist enters a Notice Date in the Choices system as follows:

- the appointment date for an individual who is a mandatory Choices registrant, or
- the report date for an exempt volunteer.

TIERS adds one month to the notice date to compute the individual's TIERS Notification Effective Date. (See A-2533.3, Deleting Months When the NED Changes.)

TIERS counts the months toward the individual's state time limit (12 or 24 months) as follows:

If the individual's work registration status is ...	TIERS counts each month ...
mandatory participant	after the month the individual is notified to participate in the Choices program.
exempt	after the month the individual • volunteers, and • has an open Choices case.
sanctioned for Choices non-participation	the individual is sanctioned for refusing to participate in the Choices program.

Beginning with the NED month, TIERS counts each month the individual

- receives TANF,
- is certified as a caretaker or second parent, and
- has an open Choices case without Choices good cause indicated, or is sanctioned for Choices non-participation.

In addition, if an individual’s work registration status is:

- mandatory registrant, or
- sanctioned for Choices non-participation, then

TIERS counts any months between the NED and the month the:

- Choices case opens, or
- individual is sanctioned.

A—2532 Counting Months for Tier 7

Revision 13-2; Effective April 1, 2013

TANF

For individuals in Tier 7, TIERS counts months beginning one year after the Choices functional literacy assessment. **Example:** The individual's Literacy Assessment Date month is 1/98 (month 0). TIERS adds 12 months and, if the Tier 7 individual meets the appropriate criteria, begins counting toward the state time limit with 2/99 (month 13.)

TIERS counts each month the individual

- receives TANF;
- is certified as a caretaker or second parent; and
- has an open Choices case without Choices good cause indicated, or is sanctioned for Choices non-participation.

If the individual does not have an open Choices case without Choices good cause indicated or is sanctioned for Choices non-participation, TIERS counts months beginning with the Notification Effective Date after the assessment anniversary date.

A—2533 Changes to State Time Limit Months Counted

Revision 13-2; Effective April 1, 2013

TANF

Evaluate the accuracy of the state time limit months counted if

- requested to do so by the individual, or
- Texas Works or Choices/Texas Workforce Commission staff discovers a possible error.

TIERS keeps a record of the individual's participation status, work registration status and work registration reason, which can change from month to month.

A—2533.1 Deleting Months When TANF Benefits are Cancelled or Recouped

Revision 13-2; Effective April 1, 2013

TANF

TIERS will remove a month counted toward the individual’s state time limit when an overpayment referral is processed for a full month’s benefits.

A—2533.2 Deleting Months in Error Situations

Revision 17-3; Effective July 1, 2017

TANF

Contact the IEE/TIERS Technical Help Desk to address any issues with the individual's Time Limited history in the following situations.

- The advisor discovers errors including incorrect work registration status or incorrect Choices penalties that result in months being counted erroneously. (**Example:** The advisor entered the individual mandatory instead of exempt while the individual was caring for a disabled child or the advisor deletes a Choices penalty in TIERS that was imposed in error.)

- Choices staff send notification that the individual's open Choices case status in TIERS is incorrect. (**Example:** The Choices automated interface sent a closed date for the Choices case status but the Choices case status is not showing closed in TIERS.)

A—2533.3 Deleting Months When the NED Changes

Revision 13-2; Effective April 1, 2013

TANF

An individual's NED may change for many reasons. A change in the NED may indicate that the Time Limited months counted before the new NED were counted in error.

Example: An exempt individual voluntarily participates in the Choices program for a few months and then stops participating. The advisor changes the individual's work registration code to mandatory when the individual is no longer eligible for the exemption. Choices then outreaches the individual and sends TIERS a new appointment date. The individual's original NED was created because the individual participated in Choices while exempt. When TIERS receives a new Choices appointment date, TIERS creates a new NED. However, all months counted before the new NED are accurate and should remain counted. Do not request that SODI delete these months.

A—2533.4 Adding State Time Limit Months

Revision 13-2; Effective April 1, 2013

TANF

The advisor should rarely request that SODI add months to the individual's Time Limited Months history. If there is a question concerning whether the months should be added, contact your regional Field Policy Specialist/mailbox (or other regional designee).

A-2540, State Time Limit Five-Year Freeze-Out Period

Body

Revision 13-2; Effective April 1, 2013

TANF

Apply the following policies during an individual's state time limit five-year freeze-out period:

- TIERS disqualifies a caretaker or second parent from TANF for five years when the individual reaches the end of a state time limit. **Exception:** Certify the individual for TANF during the freeze-out period when the individual is eligible for a hardship exemption.
- A caretaker or second parent disqualified from TANF because of state time limit policies is eligible for TANF Level Medicaid (TP08) for the 12 months that follow the maximum allowable month of the individual's state time limit.

The state time limit and hardship information in TIERS is printed on TF0001, Notice of Case Action.

A—2541 State Time Limit Five-Year Freeze-Out End Date

Revision 13-2; Effective April 1, 2013

TANF

TIERS automatically calculates the end of the individual's state time limit five-year freeze-out period. TIERS displays this date on the individual’s Time Limit page in Individual Inquiry. SAVERR-stored data converted to TIERS can be found in the Time Limit functional area in TIERS. TIERS arrives at the TL Freeze-Out End Date by adding five years to the last state Time Limited month listed on client screen A3. The individual is potentially eligible for TANF without a hardship exemption the month following the TL Freeze-Out End Date in TIERS.

The advisor cannot change the TL Freeze-Out End Date. The individual's Freeze-Out End Date changes only when the state Time Limited months listed in TIERS are adjusted. The automated systems or the advisor adjusts these months using force change procedures.

A—2542 When TIERS Takes Action Automatically

Revision 13-2; Effective April 1, 2013

TANF

TIERS automatically takes the actions described in this section when the data for the caretaker or second parent indicates that the maximum allowable number of TANF months have been counted toward the individual's state time limit.

A—2542.1 Time Limit Disqualification

Revision 13-2; Effective April 1, 2013

TANF

TIERS disqualifies a certified caretaker or second parent who has used the maximum number of months allowed in a state time limit when:

- the individual is not exempt due to receiving hardship exemption from the state time limit;
- TIERS can correctly rebudget the TANF EDG without denying it.

TIERS follows budgeting procedures for a disqualified legal parent in A-1362.1, TANF — Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits.

Exception: If the only eligible person(s) on the TANF EDG is the caretaker and/or second parent who used the maximum number of months in a state time limit, TIERS reruns eligibility for ineligible EDGs. All the children on these EDGs are disqualified because of noncompliance with employment services or receive:

- SSI;
- foster care payments; or
- adoption assistance payments.

A—2542.1.1 TIERS Procedures for SNAP EDGs When an Individual Times Out

Revision 13-2; Effective April 1, 2013

SNAP

After TIERS changes a TANF grant amount in the state time limit automated process, it:

- reruns eligibility and budgets the new TANF amount in the Supplemental Nutrition Assistance Program (SNAP) case; and
- sends a notice to the household stating the new SNAP amount.

A—2543 Hardship Exemptions

Revision 13-2; Effective April 1, 2013

TANF

An individual requests a hardship exemption by submitting Form H1010, Texas Works Application for Assistance – Your Texas Benefits, or asking to be added to the household's existing TANF or Medicaid EDG(s). Advise the household of these options whenever the individual expresses a need for assistance.

Certify a caretaker or second parent for TANF during the state time limit five-year freeze-out period when the individual:

- complied with Choices participation requirements while receiving TANF (the individual does not have a Choices penalty);
- is eligible for a hardship exemption; and
- otherwise meets TANF eligibility requirements.

There are three reasons for hardship exemptions:

Hardship	Work Registration Status
County	Time Limited Severe Economic Hardship
Employment	Time Limited Employment Hardship
Severe Personal	Time Limited Personal Hardship

A—2543.1 County Hardship Exemption

Revision 13-2; Effective April 1, 2013

TANF

HHSC designates specific Texas counties economically deprived using unemployment and other job-related criteria. HHSC lists these counties on the State Time Limit County Hardship List (C-320) and revises the list every three months.

A—2543.1.1 TIERS Action

Revision 16-2; Effective April 1, 2016

TANF

Using the State Time Limit County Hardship List, TIERS performs the following case actions:

If a certified TANF caretaker, or second parent ...	and the individual's residence county is ...	then TIERS ...
reaches the end of a state time limit (The individual does not have a hardship exemption from the state time limit.)	on the county hardship list,	• changes the individual's work registration status to Code L (Time Limited Severe Economic Hardship, Lives in Economically Deprived County) • sends a notice to the household stating the ◦ individual used the maximum number of TANF months allowed in the state time limit, ◦ individual is currently eligible for TANF because the individual lives in a designated hardship county, and ◦ HHSC reevaluates the county list periodically.
is exempt from the state time limit for county hardship (The individual has a work registration status of Code L, Time Limited Severe Economic Hardship, Lives in Economically Deprived County.)	on the county hardship list,	does not take action.
is exempt from the state time limit for county hardship (The individual has a work registration status of Code L, Time Limited Severe Economic Hardship, Lives in Economically Deprived County.)	not on the county hardship list,	• disqualifies the caretaker or second parent from TANF beginning the month following the: ◦ maximum allowable months of the individual's state time limit; and/or ◦ last month the individual is eligible for a hardship exemption. • sends a notice to the household stating the: ◦ individual used the maximum number of TANF months allowed in the state time limit, ◦ individual was eligible for TANF because the individual lived in a designated hardship county, and

If a certified TANF caretaker, or second parent ...	and the individual's residence county is ...	then TIERS ...
		◦ HHSC reevaluates the county list periodically.

A—2543.1.2 Advisor Action

Revision 13-2; Effective April 1, 2013

TANF

Determine the individual's eligibility for a county hardship exemption:

- at each of the household's TANF/Medicaid case actions;
- when the individual requests the exemption; or
- when removing an employment or severe personal hardship exemption.

Use the following chart when completing a case action during the individual's freeze out period:

If the individual ...	then ...
lives in a county on the State Time Limit County Hardship List,	• change the individual's work registration status to exempt from participation due to Time Limited Severe Economic Hardship, and • send a notice to the household stating the ◦ individual is currently eligible for TANF because the individual lives in a designated hardship county, and ◦ county list is reevaluated periodically.
no longer lives in a county on the State Time Limit County Hardship List,	remove the exemption.

A—2543.2 Severe Personal Hardship Exemption

Revision 13-2; Effective April 1, 2013

TANF

An individual may qualify for a severe personal hardship exemption when there is a disabling illness or injury of:

- self; or
- close family member.

Determine the individual's eligibility for a severe personal hardship exemption:

- when the individual requests the exemption;
- when the exemption is expected to end; and
- at each complete review until the exemption is removed.

A—2543.2.1 Disabling Illness or Injury of Self

Revision 13-2; Effective April 1, 2013

TANF

Exempt an individual for severe personal hardship for a disabling illness or injury to self when:

- the individual requests the exemption within 90 days after the illness or injury begins; and
- disability is established by:
  - approval of SSI or RSDI based on disability; or
  - completion of Form H1836-A, Medical Release/Physician's Statement.

After disability is established, review the individual's eligibility for the exemption:

- when the disability is expected to end (set a special review); and
- at each complete review until the exemption is removed.

Remove the exemption when the individual is no longer disabled. Advise the individual to report to HHSC within 10 days when the hardship situation changes. The individual may state that the disability has ended or Form H1836-A may show it has ended.

A—2543.2.2 Disabling Illness or Injury of Close Family Member

Revision 13-2; Effective April 1, 2013

TANF

Determine whether to exempt an individual for severe personal hardship for caring for a close family member who has a disabling illness or injury using the following procedures:

Step	Yes	No
1. Did the individual request the exemption within 90 days after the individual was needed in the home to care for the close family member? **Note:** The person needing care must live in the individual's home.	Go to Step 2.	STOP. Do not exempt the individual for severe personal hardship.
2. Is the individual related to the family member within the following degree of relationship? The persons providing the care and needing the care must be related in one of the following ways: ◦ spouse (or second parent who is listed on the household's TANF EDG); ◦ parent (legal, adoptive, natural, or step); ◦ child (legal, adoptive, natural, or step); ◦ sibling (legal, adoptive, natural, half, or step); ◦ grandparent (extends to the degree of great-great-great); ◦ aunt or uncle (extends to the degree of great-great); ◦ niece or nephew (extends to the degree of great-great); ◦ first cousin; ◦ first cousin once removed; or ◦ spouse of any person listed above. **Note:** These relationships extend to relatives of the individual's spouse.	Request proof of relationship and go to Step 3.	STOP. Do not exempt the individual for severe personal hardship.
3. Did the individual provide a doctor's statement that verifies ◦ the disabling illness or injury of the family member, ◦ that the individual is needed in the home for more than 30 days to care for the family member, ◦ the beginning date when the individual is/was needed in the home to provide the care, and ◦ the date the need for the individual's care in the home is expected to end?	STOP. Exempt the individual for severe personal hardship.	STOP. Do not exempt the individual for severe personal hardship.

Review the individual's eligibility for the exemption:

- at each complete review until the exemption is removed; and
- when the need for care is expected to end. **Note:** Set a special review for when the need for care is expected to end before the next complete review.

Remove the exemption when the individual is no longer needed in the home to care for the close family member. Advise the individual to report to HHSC within 10 days when the hardship situation changes.

A—2543.3 Employment Hardship Exemption

Revision 13-2; Effective April 1, 2013

TANF

Determine whether to exempt an individual for employment hardship using the following procedures:

Step	Yes	No
1. Did the individual request the exemption within 90 days after the ◦ end of the individual's state time limit, or ◦ last day of the individual's employment, or ◦ individual's work hours were reduced?	Go to Step 2.	STOP. Do not exempt the individual for employment hardship.
2. Does the individual have ongoing monthly earnings (including self-employment earnings) of less than $168 or is unemployed?	Go to Step 3.	STOP. Do not exempt the individual for employment hardship.
3. Has the individual ◦ been dismissed from a job or demoted for cause, ◦ voluntarily quit a job or reduced hours of work, or ◦ failed to accept a job offer paying at least $168 a month or an offer of additional work resulting in a total of at least $168 a month?	Go to Step 4.	Go to Step 5.
4. Did the individual have good cause according to the SNAP good cause criteria in A-1860, Determining Good Cause?	Document the good cause and go to Step 5.	STOP. Do not exempt the individual for employment hardship.
5. Does the individual meet the employer contact requirements described in Item A-2543.3.1, Initial Request, A-2543.3.2, Continuation of Exemption, and/or A-2543.3.3, Reapplication After Denial?	STOP. Exempt the individual for employment hardship.	STOP. Do not exempt the individual for employment hardship.

Determine the individual's eligibility for an employment hardship exemption:

- when the individual requests the exemption; and
- at each complete review until the exemption is removed.

A—2543.3.1 Initial Request

Revision 13-2; Effective April 1, 2013

TANF

An initial request is the first time an individual requests an employment hardship exemption after the:

- end of the individual's state time limit;

- last day of the individual's employment; or
- reduction of individual's work hours.

In addition, after the individual's employment hardship exemption is removed, the individual may request another initial employment hardship exemption when the:

- individual loses another job; or
- individual's work hours are again reduced.

An individual is eligible for an initial employment hardship exemption after contacting 40 employers in the 30-day period following the day the advisor explains the employer contact requirement to the household:

- during an interview; or
- on Form H1020, Request for Information or Action, when processing a report of change.

The advisor must give the individual Form H2776, Job Search Worksheet for TANF Employment Hardship Exemption, to help the individual provide documentation of the employer contacts. However, the individual may provide any available documentation that substantiates the:

- name, address, and telephone number of each employer contacted;
- person contacted;
- date of contact; and
- result.

Advise the individual that employer contacts may be made:

- in person;
- by telephone; or
- by other agencies on the individual's behalf. **Examples:** Texas Workforce Commission, labor organization and local workforce centers. The individual must provide documentation from the agency that made the contacts on the individual's behalf.

If, during the 30-day period, the individual ...	then ...
contacted 40 employers,	• exempt the individual for employment hardship, • provide the individual with one Form H2776 for each month that 40 contacts are required, and • advise the household that the individual ◦ must contact an average of 40 employers during each calendar month the individual is certified for TANF; ◦ must provide verification of the employer contacts at the next complete review; and ◦ will not be eligible for another employment hardship exemption during the freeze out period if the individual fails, without good cause, to meet the monthly 40 employer contact requirement.
did not contact 40 employers,	deny the request for an employment hardship exemption. **Note:** There is no good cause for not meeting this requirement. However, the individual may apply for the exemption again and receive a new 30-day period.

See A-2543.3.3, Reapplication After Denial, when a individual reapplies and was previously denied while receiving an employment hardship exemption.

A—2543.3.2 Continuation of Exemption

Revision 13-2; Effective April 1, 2013

TANF

At the complete review after the individual receives an employment hardship exemption, determine whether the individual contacted an average of 40 employers during each month the individual was certified for TANF. If the individual worked during one or more months in which the individual was required to meet the employer contact requirement, give the individual credit for two employer contacts for each day of the month worked.

If the individual did not contact an average of 40 employers a month, see A-2543.3.4, Good Cause for Not Contacting Employers While Receiving TANF.

If the individual ...	and, according to A-2543.3.4, the individual ...	then ...
contacted an average of 40 employers a month,	N/A	• continue exempting the individual for employment hardship, and • provide the individual with one Form H2776, Job Search Worksheet for TANF Employment Hardship Exemption, for each month through the month of the next complete review.
did not contact an average of 40 employers a month,	had good cause,	follow the procedures in the box above.
did not contact an average of 40 employers a month,	did not have good cause,	• remove the employment hardship exemption, and • advise the household that the individual is not eligible to receive this exemption again during the remainder of the individual's five-year freeze out period.

A—2543.3.3 Reapplication After Denial

Revision 13-2; Effective April 1, 2013

TANF

If an individual receiving a hardship exemption is denied for another reason and files an application:

- before missing one full month's benefits, use policy in A-2543.3.2, Continuation of Exemption;
- after missing at least one full month's benefits, use the following chart.

Request documentation that the individual contacted an average of 40 employers during each month the individual previously received TANF. Verify when questionable.

If the individual ...	and, according to A-2543.3.4, the individual ...	then ...
contacted an average of 40 employers a month,	N/A	follow the procedures in A-2543.3.1,Initial Request.
did not contact an average of 40 employers a month,	had good cause,	follow the procedures in A-2543.3.1, Initial Request.
did not contact an average of 40 employers a month,	did not have good cause,	• remove the employment hardship exemption, and • advise the household that the individual is not eligible to receive this exemption during the remainder of the individual's five-year freeze out period.

An individual who does not provide the documentation is the same as an individual who did not contact an average of 40 employers a month without good cause. If the individual provides the documentation later, consider the date the individual provides the documentation as a new request date.

A—2543.3.4 Good Cause for Not Contacting Employers While Receiving TANF

Revision 13-2; Effective April 1, 2013

TANF

Using prudent advisor judgment, determine and document good cause when the individual did not contact an average of 40 employers during each month the individual was certified for TANF with an employment hardship exemption.

The individual has good cause for not meeting the employer contact requirement when:

- the individual was temporarily incapacitated or ill, including the 90 days after giving birth; or
- there were no employers, or under the minimum number of employers required, within reasonable commuting distance; or
- there were circumstances beyond the individual's control (such as a disaster, or a death in the family).

A-2550, Notices

Body

Revision 13-2; Effective April 1, 2013

A—2551 Client Notices

Revision 13-2; Effective April 1, 2013

TANF

Provide the household with a written explanation of the state time limit(s) for each certified caretaker and/or second parent, using the TF0001, Notice of Case Action.

TIERS provides:

- initial state time limit information:
  - at application; or
  - when adding a new caretaker or second parent to the household.
- information about the new state time limit when it changes because of:
  - reapplication; or
  - error.
- information that a penalty for Choices noncompliance causes ineligibility for a state time limit hardship exemption during the individual's five year freeze-out period at:
  - application; and
  - each complete review.
- the number of cash assistance months used out of the number allowed at each:
  - complete review; and
  - incomplete review.
- information that an individual with work registration status of exempt from participation due to time limited severe economic hardship is mandatory for Choices.

A—2552 TIERS Notices Sent to Clients

Revision 13-2; Effective April 1, 2013

TANF

TIERS notifies individuals on the TF0001, Notice of Case Action, for the state time limit reasons described in the chart below. When appropriate, the notices include information on hardships available during the freeze-out period.

If TIERS ...	then TIERS informs the household ...
• has no tier set and Choices sends the work history and education information for TIERS to set a tier, • indicates the individual's functional literacy level changes the tier, or • shows months counted toward the state time limit are before months already counted,	of the state time limits and/or a change in the time limits.

If TIERS ...	then TIERS informs the household ...
exempts an individual for county hardship at the end of the state time limit,	that the individual used the maximum number of TANF months, but will remain on TANF due to county hardship.
disqualifies the individual from TANF,	of the new TANF benefit amount and the hardships that are available during the disqualification period.
certifies a member for TANF Level Medicaid (TP 08),	of the specific months of transitional Medicaid eligibility and the reporting requirements.
adjusts Supplemental Nutrition Assistance Program (SNAP) benefits after adjusting the TANF benefit amount,	of the new SNAP amount or the denial of the SNAP case.
removes work registration status of exempt from participation due to time limited severe economic hardship,	that the individual is disqualified from TANF because the county is no longer a designated hardship county.
denies the TP 08 EDG at the end of the 12-month period,	of the end of transitional Medicaid coverage and to contact the advisor for Medicaid if household members are certified for Medicaid or TANF.

A-2560, TANF-SP 60-Month Time Limit

Body

Revision 13-2; Effective April 1, 2013

A—2561 General Policy

Revision 13-2; Effective April 1, 2013

TANF-SP

Caretakers and second parents are limited to 60 months of TANF-SP benefits. Each caretaker and second parent has their own separate TANF-SP time limit clock. When a caretaker or second parent reaches the 60th month of the TANF-SP time limit (regardless of who reaches it first), deny the entire household at the end of the 60th month. Do not count TANF-SP benefits an eligible child receives toward the time limit if the child is later certified as a caretaker or second parent.

Months a caretaker or second parent receive TANF-SP do not count toward their federal time limit.

Related Policy

General Policy, A-1910

A—2562 Determining TANF-SP Time Limit Months

Revision 13-2; Effective April 1, 2013

TANF-SP

Effective October 2001, any month a caretaker or second parent receives a TANF-SP benefit counts toward their TANF-SP time limit (TANF-SP TL). Additionally, any TANF benefit that counts towards a caretaker's or second parent's federal time limit also counts toward their TANF-SP TL. Do not count TANF-SP benefits received in another state.

Do not count a month toward the TANF-SP TL if the household's grant is

- cancelled and not reissued,
- cancelled and reissued without including the caretaker and second parent's needs, or
- totally claimed as an overpayment.

A—2563 Tracking TANF-SP Time Limit Months

Revision 13-2; Effective April 1, 2013

TANF-SP

Effective October 1, 2001, a TANF-SP month counts for a caretaker and/or second parent when

- processing Form H1010 , Texas Works Application – Your Texas Benefits, and a TANF-SP benefit is issued,
- processing Form H1010 to:
  - add an adult recipient to the household, or
  - change an adult household member from a non-recipient to a recipient.
    Note: Each month a caretaker or second parent receives a cash benefit it is either a TANF benefit or TANF-SP benefit, but never both.

Include all federal time limit months when determining a caretaker or second parent's total countable months of TANF-SP.

A—2563.1 Denying Clients at the End of the TANF-SP 60 Months

Revision 13-2; Effective April 1, 2013

A report that identifies when the 60th TANF-SP countable benefit is issued for a caretaker or second parent is generated and sent to state office. A TANF-SP 60-Month Time Limit memo is sent to the regions after cut-off of the 59th month.

Advisors determine if the caretaker or second parent has received 60 months of countable benefits by checking the TIERS Time Limit TANF State Summary.

If the countable months are correct the advisor must:

- document in case comments that the caretaker or second parent received his lifetime limit of TANF-SP benefits and the household is no longer eligible for TANF-SP,
- send TF0001, Notice of Case Action, with the following message:

  "Your household is no longer eligible for TANF-SP benefits because (name of the caretaker/second parent) has reached the end of the state time limit. Your household may still be eligible for Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits even if you are working. If you have any questions please contact your Texas Works advisor or call 1-800-252-9300."

  "Su casa ya no califica para recibir beneficios de TANF-SP porque (name of caretaker/second parent) alcanzó el tiempo límite estatal. Es posible que su casa todavía tenga derecho de recibir beneficios de Medicaid y beneficios de comida del Programa SNAP aunque usted esté trabajando. Si tiene alguna pregunta, por favor, comuníquese con el consejero de Texas Trabaja o llame al 1-800-252-9300."

A caretaker or second parent who is denied TANF-SP when either one or both parents receive the lifetime limit of TANF-SP, cannot be certified on another TANF-SP case. Benefits received as an eligible child do not count if the child is later certified as a caretaker or second parent.

See A-1930, Extended TANF and Hardship Exemptions, when an individual reaches their 60th month and applies for extended TANF.

A—2564 Client Notices

Revision 13-2; Effective April 1, 2013

TANF-SP

TIERS provides initial TANF-SP time limit information on TF0001, Notice of Case Action:

- at application,
- when adding a new caretaker or second parent, or
- at complete review if the caretaker/second parent have not previously been informed of the TANF-SP time limit.

A-2570, Verification Requirements

Body

Revision 13-2; Effective April 1, 2013

TANF

For employment hardship exemptions:

- verify the hours worked and the pay received, if questionable; and
- accept the individual's documentation unless it is questionable. If the documentation is questionable, contact two or three employers for the period covered to verify the individual's records.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A-2580, Documentation Requirements

Body

Revision 13-2; Effective April 1, 2013

TANF

Document the:

- individual's statement of the hours worked and the pay received when determining the time limit tier;
- reason for a hardship exemption (see A-2543, Hardship Exemptions); and
- reason why a hardship exemption was denied.

If the individual is a mandatory Choices participant, document that Choices requirements and the consequences of noncooperation were explained.

TANF-SP

Advisors must document that they informed the caretaker/second parent:

- of the TANF-SP 60-month time limit at application, periodic review (if not previously informed) or when adding a new caretaker/second parent to the household; and
- that federal time limit (FTL) months count toward the TANF-SP 60-month time limit.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

Part B, Case Management

B-100, Processing Time Frames

B-110, Applications

Body

B-111 Reuse of an Application Form After Denial

Revision 21-3; Effective July 1, 2021

All Programs

The original application form is valid for up to 60 days if an applicant reapplies after being denied for:

- missing an appointment;
- failing to furnish information or verification;
- failure to provide postponed verification; or
- failure to provide proof of U.S. citizenship.

Notes:

- If the information on the application form has changed or is more than 45 days old, applicants and staff must update the form.
- If the application has been denied for missing an appointment, the denied application is reopened using the contact date as the new file date.
- Do not request more income verification when reopening a redetermination denied for failure to provide information. The original income verification the person provided at the interview date is acceptable, unless the household indicates a change in income.

TP 32 and TP 56

An application may be used more than one time for TP 56 and TP 32 applicants when *both* of the following conditions exist:

- the application interview or process date is after the application month; and
- the household states that it wishes to reapply and reuse an application form.

Related Policy

Denied for Missed Appointments, B-122.3.1
Denied for Failure to Provide Information/Verification, B-122.3.2

B-112 Deadlines

Revision 20-4; Effective October 1, 2020

TANF and Medical Programs

Provide Form TF0001, Notice of Case Action, to a certified or denied applicant by the 45th day after the file date.

Ensure that certified applicants have access to benefits by the 45th day after the file date.

Follow A-140, Expedited Service, for TP 40 expedited Eligibility Determination Groups (EDGs).

Follow Expedited Eligibility and Enrollment of Active Duty Military Members and Their Dependents, policy for expedited time frames for medical program applicants with an active duty military connection.

Exceptions:

- For applications requiring medical verification, the total processing time of the delay caused by obtaining Form H3038, Emergency Medical Services Certification, is not counted.
- Document the date that:
  - Form H3038 was sent to the practitioner or given to the applicant; and
  - medical information was received.
- For TANF reapplications with open Choices or school attendance penalties, a period of up to 40 days is excluded from timeliness calculations. The person must demonstrate cooperation for 30 days before staff close the penalty and process the application.

SNAP

By the 30th day after the file date:

- deny or certify an application; and
- ensure that a certified applicant has an opportunity to participate.

Exception: For expedited service, see A-140.

Medical Programs

Provide Form TF0001, Notice of Case Action, to a certified or denied applicant, including those with spend down by the 45th day from the file date.

Related Policy

Expedited Service, A-140
Postponed Verification Procedures, A-145.1
Expedited Eligibility and Enrollment of Active Duty Military Members and Their Dependents, A-147
Eligibility Dates and Benefit Amounts, A-2320
Children's Medicaid Redetermination Expectations, B-123.6

B-113 Delay in Processing Applications

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must follow policy below when an application is delayed until the 60th day after the file date:

If ...	then ...
the agency is at fault for not completing the application process by the 60th day after the file date and was also at fault for delaying it during the first 30 days after the file date,	the advisor must continue to process the original application and provide benefits retroactive to the file date (or the month the individual met all requirements, if later). If the applicant: • misses a Supplemental Nutrition Assistance Program (SNAP) appointment and fails to contact the office by the 10th day as noted on Form H1020, Request for Information or Action, to request a second appointment, the application is denied the following workday. The household loses eligibility for all past months and must reapply if they still want to receive benefits. • fails to provide all the required verification by the 10th day noted on Form H1020, then deny the application the following workday. If the household subsequently provides the missing verification within 10 days after the Form H1020 due date, reopen the application using the original file date. Otherwise, the household must reapply if they want to receive benefits.
HHSC was at fault in the first 30 days and the individual was at fault in the second 30 days,	deny the application on the 60th day after the file date and provide no benefits.
the individual was at fault the first 30 days and HHSC was at fault in the second 30 days,	the advisor must continue to process the original application and provide benefits retroactive to the month following the month of application (or the month the individual met all requirements, if later).

B-113.1 Reserved for Future Use

Revision 22-4; Effective Oct. 1, 2022

B-114 Missed Appointment

Revision 26-2; Effective April 1, 2026

TANF and SNAP

Make at least two attempts to contact the applicant by phone. Mail Form H1830-FA, Application, Review, Expiration or Appointment Notice, to the applicant if staff cannot contact the applicant or authorized representative (AR) by phone or the applicant is not available for the interview during the first cold call attempt. Form H1830-FA instructs the person to call the Flexible Appointment toll-free number:

- by seven calendar days after the date of the first cold call attempt; and
- during the business day.

Exception: Expedited SNAP applicants are instructed to call the Flexible Appointment toll-free number within three business days after the first cold call attempt.

Applicants can complete an interview with staff by calling the Flexible Appointment toll-free number listed on Form H1830-FA.

If the applicant does not contact HHSC by the date listed on Form H1830-FA, send Form H1020-MA-FA, Request for Information or Action-Missed Appointment-Flexible Appointment, to inform the applicant of the final date to complete their interview. The applicant has until close of business on the final due date to contact HHSC for an interview.

Exception: TANF must be denied by the due date on Form H1830-FA if the interview was not completed.

Notes:

The final due date on Form H1020-MA-FA follows time frames in related policy, SNAP Timeliness Charts for Applications and All Redeterminations.

Process the non-interview required programs if a joint application is received requesting interview and non-interview required programs, and the applicant misses a required interview.

Related Policy

Interviews, A-131
Reuse of an Application Form After Denial, B-111
Processing Redeterminations, B-122
Denied for Missed Appointments, B-122.3.1
Children's Medicaid Redetermination Expectations, B-123.6
SNAP Timeliness Charts for Applications and All Redeterminations, B-160

TP 08, TA 31, TP 36 and TP 40

No appointment is required to process an application.

Note: For requested interviews, inform the household an interview is not required if contact is made with the applicant.

If an interview is requested by the applicant and they fail to keep it, staff process the application without an interview. Do not deny the EDG for a missed appointment or send Form H1020-MA-FA.

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

No appointment is required to process an application or renewal unless a recipient non-complies with the Health Care Orientation requirement, non-complies with Texas Health Steps, or information needed to determine eligibility can only be obtained through a phone interview.

Note: For requested interviews, inform the household an interview is not required if contact is made with the applicant.

If an interview is requested by the applicant and they fail to keep it, staff process the application without an interview. Do not deny the EDG for a missed appointment or send Form H1020-MA-FA.

Related Policy

Scheduling Appointments, A-122.2
Interviews, A-131
Compliance Requirements, A-1531.5
Processing Children's Medicaid Redeterminations, B-123

B-115 Pending Verification on Applications

Revision 25-1; Effective Jan. 1, 2025

All Programs

If more information or verification is required to complete an application, allow the household at least 10 calendar days to provide the information or verification. The due date must be a business day.

Request documents that are readily available to the household if the documents are anticipated to be enough verification. Each handbook section lists potential verification sources.

Send Form H1020, Request for Information or Action, to the applicant explaining:

- what is required;
- the date the verification or information is due; and
- the date the application will be denied if the items requested are not received.

The Form H1020 request date is considered day zero of the pending period. The final due date on Form H1020 must be 30 days from the date of application or the next business day if the 30th day is not a business day. Take the appropriate action on the final due date.

If the applicant does not provide the verification, deny the application no earlier than the:

- 30th day; or
- following business day if the 30th day is not a business day.

Exceptions:

- Hold the application past the 30th day as needed to allow the household at least 10 days to provide verification. If the household does not provide requested information by the due date, deny the EDG no earlier than the following business day. This includes situations when the 10th day falls on the 30th day.
- If the eligibility factor in question does not affect the eligibility of the entire household, disqualify the ineligible member and certify the remaining members.

Reopen the application using the date the person provided verification as the new file date if:

- an application is denied for failure to provide information or postponed verification; and
- the household provides the required verification within 60 days of the file date.

Exception: For all applications or required verifications received outside of normal business hours when HHSC is closed, including weekends and holidays, the file date is the next business day.

TANF

For applications in pay for performance with a noncooperation for Choices or school attendance, the final due date is the 40th day from the date of interview.

Note: When an application is pended for eligibility verification in addition to the verification of Choices or school attendance cooperation, continue to pend the TANF application until the final due date, which is the 40th day from the interview, before taking appropriate action on the TANF EDG.

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

Check for any associated EDGs and use appropriate verifications from those EDGs when the person does not provide verification with the application form. Use proof of alien status, income or deductions, if provided within 90 days of the file date, from an associated SNAP, Medicaid or TANF EDG as verification for a child's Medicaid application or redetermination.

SNAP

If the applicant is eligible, provide an opportunity to participate by the 30th day after the file date. If not possible, benefits are authorized with priority issuance the day the person provides the required verification.

Related Policy

Expedited Service, A-140
Open Penalty at Reapplication in Pay for Performance, A-2151
Verification and Documentation, C-900

B-115.1 Pending Verification for MA – Pregnant Women – Emergency

Revision 15-4; Effective October 1, 2015

TP 36

An application for a TP 36 is denied by the 45th day after the file date if the applicant:

- or her representative does not provide Form H3038, Emergency Medical Services Certification; Form H3038-P, CHIP Perinatal — Emergency Medical Services Certification; or other required verification; and
- had at least 10 days to provide the verification.

Advisors use the following chart to process the application for the individual's emergency condition if the required verification is received:

If the emergency condition occurs...	and Form H3038/H3038-P is received ...	then ...
during the month of application,	by the 45th day after the file date,	dispose the EDG using the original file date.
during the month of application,	after the EDG is denied but by the 60th day after the file date,	reopen the EDG, using the same application, as specified in B-111, Reuse of Application Form After Denial. Use the date Form H3038 or Form H3038-P is received as the new file date.*
after the application month but by the 60th day after the file date,	by the 45th day after the file date,	use the date Form H3038/H3038-P is received as the file date.*
after the application month but by the 60th day after the file date,	after the EDG is denied but by the 60th day after the file date,	reopen the EDG, using the same application, as specified in B-111. Use the date Form H3038/H3038-P is received as the new file date.*

* Form H1113, Application for Prior Medicaid Coverage, is not required if processing the emergency coverage for a prior month.

B-116 Information Reported During Application Processing

Revision 15-4; Effective October 1, 2015

All Programs

In determining eligibility, the advisor must consider any information the individual reports between the application date and the decision date. The advisor must include any information the individual reports in the application decision process and send Form H1020, if verification of the reported information is required to complete the application process, following procedures in B-115, Pending Verification on Applications.

Advisors must add a new household member the month the household member joins the household. For newborns, this is the:

- birth month for TANF and Medical Programs, and
- month the newborn comes home from the hospital for SNAP.

If the household has an existing case and submits a new application that includes new information, such as a new job, advisors must address changes that may impact eligibility for other programs.

Related Policy

Receipt of Duplicate Application, A-121.2
Receipt of Identical Application, A-121.3

B-120, Redeterminations

Body

Revision 26-2; Effective April 1, 2026

TANF, SNAP, TP 08, TP 43, TP 44 and TP 48

Redetermination is the generic term in the eligibility determination system and the State Portal used to identify:

- periodic reviews of TANF;
- recertification of SNAP; and
- renewal TP 08, TP 43, TP 44 and TP 48.

Note: Certification periods and redeterminations for people on Medical Programs who are receiving TANF and SNAP may not align. If the household reports new information during a redetermination, such as a new job, staff must address changes that may impact eligibility for other programs.

Redeterminations must be signed and can be submitted by mail, fax, phone, or the Your Texas Benefits website.

Related Policy

Application Requests and Submissions, A-113
Application Signature, A-122.1

TANF and SNAP

Form H1830-R, Texas Works Renewal Notice, is sent to households, along with Form H1010-R, Your Texas Benefits: Renewal Form, or Form H0011-R, Texas Simplified Application Project (TSAP) for SNAP Food Benefits Renewal for redeterminations.

B-121 Notice of Redetermination and Certification Expiration

Revision 26-2; Effective April 1, 2026

TANF

The eligibility determination system automatically sends the Texas Works redetermination packet 60 days before the review due date for approved Eligibility Determination Groups (EDGs).

Attempt two cold calls to complete an interview after the household returns Form H1010-R, Your Texas Works Benefits: Renewal Form. Schedule an appointment for unsuccessful cold call attempts by mailing Form H1830, Application, Review, Expiration or Appointment Notice, to the household.

SNAP

The eligibility determination system automatically sends the Texas Works redetermination packet during the first week of the month before last benefit month (LBM).

Attempt two cold calls to complete an interview after the household returns the Form H1010-R. Schedule an appointment for unsuccessful cold call attempts by mailing Form H1830.

The person must contact the Flexible Appointment toll-free number provided on Form H1830, for timely redeterminations. They must do this early enough in the last benefit month to allow at least 13 days after the interview to ensure the EDG can be disposed by the last day of the certification period. This allows two days mail time for Form H1020, Request for Information or Action, from the central mail facility and 10 days after the Form H1020 issue date for the household to provide the information.

Note: If the 10th day falls on a non-business day, the due date is the following business day.

Related Policy

Redetermination, B-476.1.6

TP 08, TP 43, TP 44 and TP 48

The eligibility determination system automatically sends renewal correspondence in the ninth month of the 12-month certification period.

The eligibility determination system automatically sends Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter. Form H1211 is dynamic, based on the eligibility outcome and program.

The eligibility determination system automatically sends Form H1020 with Form H1211 when more information or verifications are needed to complete the renewal processing.

The eligibility determination system generates Form H1206, Health Care Benefits Renewal, but does not automatically send it. Staff action is required. Form H1206 is pre-populated with information from the recipient's case and may also include information from electronic data sources. There are different versions of this form depending on the type of assistance the person receives. Recipients can access Form H1206 using the following methods:

- logging into their Your Texas Benefits full-access account and selecting the Letters and forms tab to view or print the form;
- dialing 2-1-1, selecting option 2, and requesting that Form H1206 be mailed to them; or
- visiting an HHSC local office and receiving lobby help to access the form through their Your Texas Benefits account or having HHSC local office staff print a copy of the form.

The system generates Form M5017, Documents to Send with Your Renewal Application, to include with Form H1206, but does not automatically mail them. Staff action is required.

When a new person is added to a case or a person is transferred to a different medical program, their review due date may be aligned with the review due date of another person in the same medical program on the case. They will be able to renew at the same time. If the review due dates are aligned after the system initiated the automated renewal process by requesting electronic data sources, the following forms are manually mailed to the new person or the person who was transferred to a different type of assistance to complete the processing:

- Form H1830-R, Texas Works Renewal Notice; and
- Form H1010-R, Your Texas Works Benefits - Renewal Form.

Related Policy

Receipt of Application, A-121
Application Signature, A-122.1
Additions to the Household, B-641

B-122 Processing Redeterminations

Revision 26-2; Effective April 1, 2026

TANF

Process redeterminations before cutoff in the month:

- the redetermination date occurs if the redetermination is due on or before cutoff; or
- after the redetermination date if the redetermination is due after cutoff.

When the Texas Works Renewal Packet Is Returned and a Packet Received Date Is Entered

If the household must provide verification to complete the redetermination, allow at least 10 calendar days to provide verification.

Follow the related policy about scheduling appointments and missed appointments to conduct an interview.

When the Texas Works Renewal Packet Is Not Returned, a Packet Received Date Is Not Entered, or Both

The eligibility determination system runs a Mass Update (MU) on the fifth, sixth or seventh day of each month to terminate EDGs with due dates on or before cutoff of the current month if a renewal packet is not received.

For example, on July 5, the MU terminates EDGs with a review due date on or before July cutoff.

Normal MU rules for exceptions may prevent an EDG from being terminated. Process these EDGs and verify that a Texas Works renewal packet was sent and not returned.

When the Texas Works renewal packet is:

- Not returned, go to Initiate Interview in Change Action mode, run eligibility and dispose the TANF EDG.
- Returned, go to Initiate Interview in Ongoing mode and enter the packet received date in the Miscellaneous Packet Received logical unit of work (LUW).

Schedule an appointment to process the complete redetermination if the household returns Form H1010–R, Your Texas Works Benefits: Renewal Form, within the adverse action period. These EDGs must be processed as a Redetermination for correct eligibility determination and timeliness calculation.

Where to Find the Packet Received Date

In State Portal, the packet received date can be found in PT Inquiry in the EDG Details section in the column labeled **Recertification Packet Date**.

In TIERS, the packet received date can be found in two places in **Data Collection**:

- **Miscellaneous – Packet Received** LUW, which can be viewed in any mode; and
- **Initiate Interview – Initiate Review** page, which can be viewed only in Complete Action mode.

Related Policy

Scheduling Appointments, A-122.2
The Texas Works Message, A-1527
Missed Appointment, B-114
Data Broker, C-820

SNAP

SNAP households are mailed redetermination packets during the first week of the month before their last benefit month. If the household returns the redetermination packet:

- by the 15th of the last benefit month, the redetermination is considered timely.
- on or after the 16th of the last benefit month through the 30th day after the certification period ends, the redetermination is considered untimely. Redeterminations filed in the 30 days after the end of the certification period should be screened for expedited benefits if eligible.
- on or after the 31st day after the certification period ends, the redetermination packet is considered an application and should be screened for expedited benefits if eligible.

Exception: Refer to B-122.1, SNAP Redeterminations Following a Short Certification. Follow the related policy for scheduled and missed appointments to conduct an interview.

If the household **does not** contact HHSC by the last business day of the certification period to complete an interview, the redetermination application is denied on the last business day of the certification period using adequate notice.

Process timely redeterminations by the last business day of the certification period. If the redetermination is pended for verification, the household is allowed until the last business day of the month to provide the required verification before denial action is taken. Ensure the person's normal issuance cycle is not interrupted.

Exception: The redetermination is pended past the last business day of the month when needed to allow the person at least 10 calendar days to provide requested verification. If the person:

- Provides verification before the end of the current certification month, then the action is processed by the last day of the month.
- Provides verification after the end of the certification period but by the end of the 10-day period, ensure that the household receives an opportunity to participate within five business days of receipt of the verification, if eligible. If the household is not eligible, the denial is processed by the fifth business day after receipt of verification.

- Does not provide verification by the end of the 10-day period, the redetermination is denied the next business day.

Related Policy

Scheduling Appointments, A-122.2
Interviews, A-131
Missed Appointment, B-114
SNAP Redeterminations Following a Short Certification, B-122.1
Children's Medicaid Redetermination Expectations, B-123.6
Redetermination, B-476.1.6

TP 08, TP 43, TP 44 and TP 48

These programs complete an administrative renewal process, explained in B-122.4, Medical Program Administrative Renewals.

TP 07 and TP 20

Retest recipients of TP 07 and TP 20 for eligibility in other medical programs following the related policy for retesting eligibility at the end of their certification period. These people are referred to the Marketplace if they are determined ineligible for all other medical programs.

Related Policy

Retesting Eligibility, A-2342.1
Denied for Failure to Provide Information/Verification, B-122.3.2
Processing Untimely Redeterminations, B-124
SNAP Timeliness Charts for Applications and All Redeterminations, B-160
Required Verification, C-910

B-122.1 SNAP Redeterminations Following a Short Certification

Revision 13-3; Effective July 1, 2013

SNAP

Advisors must provide eligible households with benefits by the 30th day after the last monthly full benefit was provided if the individual reapplied timely and was previously certified with a short certification. A short certification is defined as a SNAP certification in which the household is certified:

- for a one-month period; or
- in the second month of a two-month certification.

The household must reapply within 15 days of receiving Form H1830, Application/Review/Expiration/Appointment Notice, and the application for assistance to be considered timely.

Notes:

- This policy does not apply to households that are certified in the first month of a two-month certification. These households must continue to file their Form H1010 by the 15th of the last benefit month for a timely redetermination. Advisors must continue to process timely redeterminations on these cases by the last day of the current certification period.
- Advisors must continue to provide Form H1830 and an application for assistance to households that are certified in the first month of a two-month certification or after cutoff in the first month of a three-month certification, because these households will not receive a redetermination packet even though they are not considered to have received a short certification.

B-122.1.1 Calculating the 30-Day Period After the Last Monthly Full Benefit

Revision 15-4; Effective October 1, 2015

SNAP

To calculate the 30-day period, the advisor considers the date the individual received the last full benefit as day zero. If the 30th day falls on a non-workday, the advisor must complete the case by the last workday preceding the 30th day.

B-122.1.2 Determining the Date the Client Must File the Application for a Timely Redetermination Following a Short Certification

Revision 15-4; Effective October 1, 2015

SNAP

To calculate the date the individual must file the application to be considered timely, the advisor must count 15 days after the individual received Form H1830, Application/Review/Expiration/Appointment Notice, and the application for assistance. This date is known as the Short Certification Timely Due Date. If the 15th day falls on a weekend or a holiday, the individual must submit the application before the 15th day in order for it to be considered a timely redetermination.

Advisors must follow the chart below in determining a timely redetermination:

If Form H1830 and Form H1010 are...	then count 15 days ...
given to the individual in the office,	after the date the individual is given the forms.
mailed to the individual,	plus two days (17 days) after the date the forms are mailed.

To schedule timely redeterminations properly, scheduling staff need to know the due date on which the application must be submitted to be considered a timely redetermination. Therefore, when providing Form H1830 and Form H1010, Application for Assistance — Your Texas Benefits, at the time a short certification is completed, advisors must manually document the due date in the Short Cert. Timely Due Date box in the Agency Use Only section of Form H1010. Scheduling staff must then follow B-160, SNAP Timeliness Charts for Applications and All Redeterminations, to properly schedule the appointment.

B-122.1.3 Missed Appointments Following a Short Certification

Revision 22-4; Effective Oct. 1, 2022

SNAP

Send Form H1020-MA-FA, Request for Information or Action-Missed Appointment, for reapplications submitted timely after a short certification, if a person does not complete an interview on or before the date on Form H1830-FA, Application/Review/Expiration/Appointment Notice. This is to inform the household they must contact HHSC by the 30th day from the last month's full benefit issuance to complete the interview.

Hold the application past the 30th day after the last month's full benefit issuance to allow the household at least 10 days (or longer if the 10th day falls on a non-business day) to provide missing information or verification. Notify the household of the due date on Form H1020. When the 10-day due date is on or after the 30th day after the last month's full benefit issuance and the household fails to provide missing information or verification by the due date, deny the application the next business day. If the household does not contact HHSC by the 30th day to complete an interview, the redetermination application is denied on the 30th day (or the last business day before the 30th day if the 30th day is not a business day).

B-122.2 HHSC Delays in Processing All Timely Redeterminations

Revision 22-4; Effective Oct. 1, 2022

SNAP

If the redetermination process is not completed in a timely manner due to agency delays, dispose the EDG the same day the eligibility redetermination is completed to ensure benefits are available within 24 hours.

Example 1: A household's last benefit month is October. The household files the redetermination timely, but HHSC does not give the household Form H1830-FA, Application/Review/Expiration/Appointment Notice, to complete their interview until November. Dispose the EDG on the same day the eligibility redetermination is completed to ensure that benefits are available within 24 hours.

Example 2: A household's last benefit month is October. The household files the redetermination, completes the interview, and provides all requested verification timely. Staff did not dispose and recertify the EDG by the last business day in October. Due to HHSC delay, staff must dispose the EDG on the same day that the eligibility redetermination is complete to ensure household has access to benefits within 24 hours.

B-122.3 Delays Caused by Households

Revision 22-4; Effective Oct. 1, 2022

TANF

If a redetermination is denied for a missed appointment or failure to provide information, allow the household until 60 days from the file date to complete an interview or provide the missing information.

SNAP

If a timely redetermination is denied for a missed appointment or failure to provide information, allow the household an additional 30 days after the end of the last benefit month to complete an interview or to provide the missing information.

Related Policy

Verification Requirements, A-1370

B-122.3.1 Denied for Missed Appointments

Revision 26-2; Effective April 1, 2026

TANF

For applications denied for a missed appointment, consider the date the household contacts the agency as the new file date. The household must complete an interview within 60 days after the original file date.

SNAP

For applications denied for a missed appointment, consider the date the household contacts the agency as the new file date. The household must complete an interview within 30 days after the end of the last benefit month. Benefits are prorated using the new file date.

B-122.3.2 Denied for Failure to Provide Information or Verification

Revision 25-4; Effective Oct. 1, 2025

All Programs

If the household is denied for failure for provide, the date the information or verification is given is the new file date.

Exception: For required verifications received outside of normal HHSC business hours when HHSC is closed, including weekends and holidays, the file date is the next business day.

TANF

The date the household provides the missing information is the new file date if the household provides the missing information within 60 days of the original file date. A new interview and a new Form H1073, Personal Responsibility Agreement, are not required if the EDG is reopened within 30 days of the denial.

SNAP

The date the household gives the missing information or verification is the new file date if the household provides the missing information within 30 days after the end of the certification period. A new interview is not required. Prorate benefits based on the new file date. Do not request more income verification when following the reuse of application policy for a redetermination denied for failure to provide information. Accept the original income verification provided at the interview date unless the household reports a change in income.

TP 08, TP 43, TP 44 and TP 48

Reopen the existing case without requiring a new application when: a renewal is denied for failure to provide information or verification; and the information or verification is given after the date of denial but by the 90th day after the last day of the last eligibility month.

Note: This may result in a gap in coverage.

B-122.4 Medical Program Administrative Renewals

Revision 26-2; Effective April 1, 2026

TP 08, TP 43, TP 44, TP 45 and TP 48

The eligibility system initiates administrative renewals without staff action. The administrative renewal process uses the automated renewal process to gather information from a household's existing case and from electronic data sources. This is to determine if the household remains eligible for Medical Programs.

Exception: Do not administratively renew:

- children whose TP 44 eligibility is reinstated on release from a juvenile facility; and
- who are released to a household different than the one where they were certified when placed in a juvenile facility.

Form H1010-R, Your Texas Benefits: Renewal Form, is required to review their Medicaid eligibility.

TP 08

An interview is not required at redetermination. If the recipient requests an interview and the interview is held, remind the recipient they may use the Your Texas Benefits website to:

- create a case access account;
- complete the renewal;
- sign-up for email reminders and electronic correspondence; and
- find out when the next renewal is due.

A person cannot be required to complete a face-to-face interview but has the right to request one.

Related Policy

Interviews, A-131
Automated Renewal Process, B-122.4.1
Medicaid Reinstatement for Children Certified for TP 44 Who Are Released from a Juvenile Facility, B-531

B-122.4.1 Automated Renewal Process

Revision 25-3; Effective July 1, 2025

TP 08, TP 43, TP 44, TP 45 and TP 48

The automated renewal process is the first step in an administrative renewal. The automated renewal process runs the weekend before cutoff in the ninth month of the certification period and does not require staff action.

The process uses electronic data to automatically:

- assess the verifications required by type program for renewals;
- determine the eligibility outcome; and
- send the renewal correspondence to the client.

B-122.4.1.1 Verifications Required by Type Program for Renewals

Revision 21-2; Effective April 1, 2021

During the automated renewal process, TIERS checks for the required verification by program.

Automated Renewal Process: Verifications Required by Type Program for Renewals

TP 08, Parents and Caretaker Relatives Medicaid	• Residence • Income and Expenses • Immigration Status • Domicile • Full-time School Attendance, when the only dependent child(ren) is 18
TP 43, Children Under Age One TP 44, Children 6–18 TP 48, Children 1–5	• Income and Expenses • Immigration Status • Texas Health Steps (only for TP 44 and TP 48) • Health Care Orientation

The automated renewal process attempts to verify income by determining if the person's income information is reasonably compatible with income information available through electronic data sources.

When there are no earned income electronic data sources (TWC) available for the person, the automated renewal process checks to see if there is a New Hire Report. When a New Hire Report exists with an employer's name and hire date that is not currently included in the person's income, the person must provide verification of income from the employer shown on the New Hire Report.

Immigration status is verified during the automated renewal process only if the person's immigration document expires during the current certification period.

Related Policy

Verification Requirements, A-1370

B-122.4.1.2 Eligibility Outcomes

Revision 15-4; Effective October 1, 2015

Once available verifications are assessed, the system runs eligibility. The following chart lists the possible eligibility outcomes of the automated renewal process.

Automated Renewal Process: Eligibility Outcomes	
Eligibility Potentially Approved	• All required eligibility information **can** be verified during the automated renewal process for the program. • No additional verification is required from a client. • Clients must review the information used to determine their eligibility. • Clients are only required to return a signed renewal Form H1206, Health Care Benefits Renewal, if the information on the renewal form is incorrect or there are changes to the client's case.
Additional Information Needed	• This outcome may be the result of two scenarios that **require additional verification** to determine whether the client remains eligible: ◦ Electronic data sources indicate there is a change in income that **may** result in ineligibility for Medical Programs. ▪ The reasonable compatibility calculation result is "Need Info because ELDS above limit" or verification required for information found on the New Hire Report. ▪ The client must return a signed renewal Form H1206, Health Care Benefits Renewal, and all required verification(s) within 30 days. ◦ No electronic data is available for the client. ▪ The client must return a signed renewal Form H1206 and all requested verification(s). • SNAP or TANF benefits may be impacted if a member of the MAGI household is included in a SNAP or TANF budget group.
Eligibility Terminated*	• This outcome may be the result of two scenarios: ◦ The previous eligibility outcome was "Additional Information Needed" and eligibility was terminated because the client: ▪ did not submit required verifications within 30 days to show that income is under the limit, or ▪ submitted verifications that showed that income was over the limit. ◦ The client reported a change in income that was over the income limit, and eligibility was terminated before the automated renewal process was triggered.

* See A-2342, Denial at Redetermination, for more information on individuals found ineligible for Medical Programs at renewal.

B-122.4.1.2.1 Determining if Verification Is Required for SNAP or TANF During an Administrative Renewal

Revision 21-2; Effective April 1, 2021

TP 08, TP 43, TP 44 and TP 48

Verification is required for SNAP and TANF during the automated administrative renewal process when:

- the eligibility outcome of the automated renewal process is “Additional Information Needed”; and
  - the reasonable compatibility calculation result is “Need Info because ELDS above limit”; or
  - the person is required to provide verification of information found on a New Hire Report; and
- a person in the MAGI household is included in a SNAP or TANF budget group.

The person has 10 days to provide verification for SNAP and TANF. Based on the income type and electronic data source used during the automated income verification process, if the person does not provide verification by the 10th day, TIERS automatically takes the following action on the 11th day:

- Denies SNAP and TANF benefits for the following data sources:
  - quarterly wage data from Texas Workforce Commission (TWC); or
  - New Hire Report data from the Office of the Attorney General (OAG).
- Notifies staff to adjust SNAP and TANF benefits for the following data sources:
  - unearned Retirement, Survivors and Disability Insurance (RSDI) income data from the Social Security Administration (SSA); or
  - unearned unemployment data from the Texas Workforce Commission (TWC).

Note: Unearned RSDI data from SSA and unearned unemployment data from TWC are valid verification sources for SNAP and TANF. Because New Hire Report data from OAG is not a valid verification source for SNAP and TANF, the person must provide verification of income from the employer shown on the New Hire Report.

B-122.4.1.3 Renewal Correspondence

Revision 15-4; Effective October 1, 2015

TP 08, TP 43, TP 44 and TP 48

The system generates client correspondence according to the eligibility outcome of the automated renewal process and the action needed by the client.

The following chart lists the correspondence generated for each eligibility outcome of the automated renewal process and the required client response.

Automated Renewal Process: Renewal Correspondence	
Eligibility Outcome	Correspondence and Required Client Response
Eligibility Potentially Approved	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, notifies the client that they must review the information used to determine their eligibility on Form H1206, Health Care Benefits Renewal - MA. • The client is only required to return a signed renewal Form H1206 if the information on the form is incorrect or there are changes to the client’s case. • Form M5017, Documents to Send with Your Renewal Application, is included with Form H1206. • No additional forms are sent with Form H1211. • Form TF0001, Notice of Case Action, is mailed to the client to notify him or her of the eligibility determination*.
Additional Information Needed	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, and Form H1020, Request for Information or Action, are sent to the client. • Form H1211 notifies the client that they must return the following: ◦ Signed renewal Form H1206, and ◦ Required verification(s). • Form H1020 identifies all the required verification(s) needed to complete the renewal. • Form M5017, Documents to Send with Your Renewal Application, is included with Form H1206. **Note:** For TP 43, TP 44, and TP 48, Form H1014-A, Children's Health Care Benefits — Final Reminder, is sent if the eligibility outcome is “Additional Information Needed” and the client does not return his or her redetermination packet by the first calendar day in the 11th month of a 12-month eligibility period.

Automated Renewal Process: Renewal Correspondence	
Eligibility Terminated	• If additional information is needed and the client **does not** return a renewal form by the 30th day from the date Form H1211 is mailed, eligibility is auto-disposed and denied. No advisor action is needed. • If additional information is needed and the client **does** return a renewal form by the 30th day from the date Form H1211 is mailed, the form is routed to local offices for processing and the advisor manually processes the renewal. • Form TF0001, Notice of Case Action, is mailed to the client to notify him or her of the eligibility determination*.

* Form TF0001, Notice of Case Action, is sent when a final eligibility determination has been made. Depending on the renewal status outcome and client action, final eligibility determinations may be made by advisors manually processing renewal documents or by the system automatically. Form TF0001 identifies the dates of the new certification period for Medicaid benefits, potential CHIP eligibility, or the denial reason for not recertifying the case.

B-122.4.2 Processing a Manual Renewal

Revision 25-3; Effective July 1, 2025

TP 07, TP 08, TP 20, TP 40, TP 43, TP 44, TP 45 and TP 48

The file date is the day that HHSC receives an acceptable Medical Program renewal form. The following are considered acceptable Medical Program renewal forms:

- Form H1206, Health Care Benefits Renewal – MA
- Form H1206, Health Care Benefits Renewal – ME
- Form H1010-R, Your Texas Benefits: Renewal Form

A redetermination is considered timely if a renewal form is received at least 30 calendar days before the end of the current certification period. A redetermination is considered untimely if a renewal form is received with less than 30 calendar days before the end of the current certification period.

Process timely redeterminations by the end of the current certification period. Process untimely redeterminations by last day of the month following the end of the current certification period. Follow the policy in B-123.4, Eligibility Transition from Medicaid to CHIP, when a person returns a renewal form timely and is determined ineligible for Medicaid but eligible for CHIP.

Examples:

Medicaid coverage period is January through December. If the redetermination file date is:

- Oct.10, the redetermination must be completed by the Dec. 31 to be considered processed timely.
- Dec. 3, the redetermination must be completed by Jan. 31 to be considered processed timely.

When HHSC receives an acceptable Medical Program renewal form, review the information provided. Determine if the case needs to be updated to reflect the most recent information reported on the form.

Only request information and verification needed to determine eligibility from the household when it is not available through electronic data sources. Verification previously provided must be used to renew eligibility when the verification is still valid. Determine if there is any verification that can be used before requesting verification from the household.

Allow at least 10 days to provide missing information. The due date must fall on a business day.

Note: Information reported during renewal processing may impact other benefit programs.

Related Policy

Eligibility Transition from Medicaid to CHIP, B-123.4

B-122.4.2.1 When a Medical Program Renewal Form Is Not Returned

Revision 15-4; Effective October 1, 2015

TP 08, TP 43, TP 44 and TP 48

When an acceptable Medical Program renewal form, explained in B-122.4.2, Processing a Manual Renewal, is not returned, the system automatically makes an eligibility determination through a mass update based on the eligibility outcome from the automated renewal process. This does not require the advisor to run eligibility or dispose the EDG.

Below are the eligibility outcomes during the automated process:

- Eligibility Potentially Approved — the client is auto-disposed and approved without advisor action. The file date is the date the EDG is auto-disposed approved, and the client is granted a new 12-month certification period.
- Additional Information Needed — the client is auto-disposed and denied without advisor action.

Note: When an individual submits income or expense verification without a signed acceptable Medical Program renewal form, advisors manually process information as a change to determine ongoing eligibility for the remainder of the certification period if the client is in a non-continuous period. A signed acceptable Medical Program renewal form is required if additional information is needed to complete the renewal during the automated renewal process.

B-123 Processing Children's Medicaid Redeterminations

Revision 15-4; Effective October 1, 2015

TP 43, TP 44 and TP 48

Renewals for TP 43, TP 44 and TP 48 use the correspondence and processing requirements explained in B-121, Notice of Redetermination/Certification Expiration (for TP 08, TP 43, TP 44 and TP 48), and B-122.4, Medical Program Administrative Renewals.

TP 44 and TP 48

TP 44 and TP 48 must follow the Texas Health Steps requirements explained in A-1531.5, Compliance Requirements.

Related Policy

Continuous Medicaid Coverage, A-832
Compliance Requirements, A-1531.5
Data Broker, C-820

B-123.1 Children's Medicaid Redetermination Due Dates

Revision 15-4; Effective October 1, 2015

TP 43, TP 44 and TP 48

Renewals for TP 43, TP 44 and TP 48 follow the administrative renewal process and use the timeliness guidelines explained in B-122.4, Medical Program Administrative Renewals.

Related Policy

Eligibility Transition from Medicaid to CHIP, B-123.4

B-123.2 Children's Medicaid Redetermination Processing Time Frames

Revision 15-4; Effective October 1, 2015

TP 43, TP 44 and TP 48

Renewals for TP 43, TP 44 and TP 48 follow the administrative renewal process and use the timeliness guidelines explained in B-122.4, Medical Program Administrative Renewals.

B-123.3 Reuse of Form H1206 After Denial

Revision 19-2; Effective April 1, 2019

TP 43, TP 44 and TP 48

TP 43, TP 44 and TP 48 follow the policy for reusing renewal forms after the date of denial explained in B-122.3.2, Denied for Failure to Provide Information/Verification.

B-123.4 Eligibility Transition from Medicaid to CHIP

Revision 25-3; Effective July 1, 2025

TP 43, TP 44, TP 45 and TP 48

The system extends Medicaid eligibility to allow the household time to complete the process and still retain coverage when:

- a child certified on TP 43, TP 44, TP 45 or TP 48 is determined eligible for CHIP at the renewal; and
- there is a delay in CHIP enrollment because of HHSC error and the redetermination packet was received timely.

The redetermination is considered timely when the renewal packet is:

- received with more than 30 days remaining in the certification period; and
- processed by HHSC by the end of the certification period.

Use the following chart to determine when to extend Medicaid coverage:

If a child is ineligible for Medicaid but eligible for CHIP and the family	but HHSC	then, provide Medicaid coverage
completes the redetermination process timely,*	does not process the form by the last day of the certification period,	through the end of the month the renewal is processed.
completes the redetermination process untimely,*	does not process the renewal by the last day of the month following the last benefit month,	through the end of the month the renewal is processed.

* Timely means the renewal form is received at least 30 calendar days before the end of the current certification period and any required verification is received within specified time frames.

*Untimely means the renewal form is received with less than 30 calendar days remaining in the current certification period.

Related Policy

Medicaid Termination, A-825
Expedited CHIP Enrollment, D-1711

B-123.5 Reserved for Future Use

Revision 25-3; Effective July 1, 2025

B-123.6 Children's Medicaid Redetermination Expectations

Revision 15-4; Effective October 1, 2015

Children's Medicaid

Staff must process Children's Medicaid redeterminations even if not requested on an associated SNAP application or redetermination, if the SNAP application or redetermination is received in the 10th, 11th or 12th month of a 12-month Children's Medicaid eligibility period.

Note: If the individual misses the appointment for a SNAP application or redetermination, staff **must** continue processing the Children's Medicaid redetermination, even if the Children's Medicaid program was not requested on the application.

The recipient must provide an application or redetermination application to process the Children's Medicaid redetermination if the SNAP application or redetermination is not received within the specified time frames.

Related Policy

Receipt of Application, A-121
Deadlines, B-112
Missed Appointment, B-114

Redeterminations, B-120
Processing Redeterminations, B-122

B-124 Processing Untimely Redeterminations

Revision 26-2; Effective April 1, 2026

SNAP

Use initial application processing time frames if a redetermination packet is received on or after the 31st day after the certification period has ended. The redetermination packet is considered an application and should be screened for expedited benefits, if eligible.

Use the related processing time frames policy in the SNAP timeliness charts for applications and all redeterminations if:

- the person submits an untimely redetermination packet; and
- does not complete an interview by the 30th day from the file date.

For phone interviews, try at least twice to contact the person. If unable to contact the applicant, mail Form H1830-FA, Application, Review, Expiration or Appointment Notice-Flexible Appointment, to notify the applicant to call the Flexible Appointment toll-free number and complete an interview.

Notes:

- Benefits are not prorated if an eligible person submits an untimely reapplication because HHSC failed to send Form H1830-R, Texas Works Renewal Notice, and Form H1010-R, Your Texas Works Benefits - Renewal Form, timely. Provide benefits from the first day of the month after the last benefit month by entering a file date of the first day of that month.
- Do not use initial application verification requirements when processing untimely redeterminations. Verification requirements for all redeterminations are the same, whether filed timely or untimely.

TP 07, TP 08, TP 20, TP 40, TP 43, TP 44, TP 45 and TP 48

If a renewal form is not received by the last day of the current certification period, deny the EDG for failure to return a renewal packet. A renewal form received after the last day of the certification period must be treated as an application using application processing time frames. The file date is the day HHSC receives the renewal form.

If the renewal form is received with less than 30 calendar days before the end of the current certification period, process the redetermination by the last day of the month following the end of the current certification period.

Example: Children's Medicaid is approved from Jan. 1, 2025, through Dec, 31, 2025.

The renewal form is submitted on Dec. 25, 2025.

Since the renewal was provided with less than 30 calendar days before the last day of the current certification period, the renewal must be processed no later than Jan. 31, 2026, to be considered timely.

Medicaid is automatically extended by one month on Dec. 31, 2025, as the renewal was returned by the last day of the current certification period, and it has not been processed.

HHSC processed the renewal on Jan. 25, 2026, and was approved for Medicaid with a new eligibility period Feb. 1, 2026, through Jan. 31, 2027.

Related Policy

Expedited Service, A-140
Missed Appointment, B-114
Deadlines, B-112
Processing Redeterminations, B-122
SNAP Timeliness Charts for Applications and All Redeterminations, B-160
Required Verification, C-910

B-125 Processing Special Reviews

Revision 15-4; Effective October 1, 2015

All Programs

Special reviews are contacts with the household outside of the redetermination process. Staff may conduct special reviews by home visits, telephone, or by mailing individuals Form H1020, Request for Information or Action, or a letter.

TANF and Medical Programs

Advisors contact the household to determine whether a change occurred. If the household confirms that no change occurred, the advisor documents the contact. To clear the special review alert task, the advisor must be in Data Collection Initiate Interview in Special Review mode. If the household confirms that a change occurred, the advisor follows policy in B-600, Changes.

If the household fails to furnish verification requested on Form H1020 or misses an appointment scheduled for the special review, the advisor must send Form TF0001, Notice of Case Action, to begin adverse action.

If the individual contacts the office during the adverse action period, the advisor must reschedule the appointment to process the review as soon as possible to avoid interruption of the benefit issuance cycle for the following month. A second Form TF0001 is not required if the individual misses the second appointment. If the individual does not keep the second appointment, the advisor uses the time frame of the original Form TF0001 to determine the effective date of the denial.

Related Policy

Setting Special Reviews, A-2330

B-125.1 Due Dates

Revision 15-4; Effective October 1, 2015

All Programs

An alert for a special review is triggered in TIERS, which generates a task in Task List Manager (TLM) for the special review.

TANF and Medical Programs

Advisors process special reviews before cutoff in the month:

- the review date falls, if the review is due on or before cutoff; or
- after the review date, if the review is due after cutoff.

SNAP

Advisors process special reviews by cutoff of the month the review date falls.

B-126 Processing Desk Reviews

Revision 26-2; Effective April 1, 2026

SNAP

A desk review is the processing of a timely or untimely SNAP redetermination without scheduling or conducting an interview with the household. Complete a SNAP redetermination by desk review when all of the following criteria are met:

- the household's current SNAP certification period is six months or less;
- the current and new SNAP certification periods combined will not exceed a total of 12 months; and
- eligibility for the current SNAP certification was determined without using the desk review process.

Exceptions: Staff must conduct an interview when the household:

- has a member who receives or is applying for TANF;
- failed to complete the application form well enough to process without an interview;
- has a member with an intentional program violation (IPV) disqualification; or
- lives in a drug or alcohol treatment center, homeless shelter, family violence shelter or group living arrangement.

Staff process a SNAP redetermination as a desk review within seven calendar days after the Packet Received Date (day zero) and issue either Form H1020, Request for Information or Action, or Form TF0001, Notice of Case Action, to the household within the same seven calendar days.

Note: When a SNAP redetermination Packet Received Date is the 10th through the 15th calendar day of the Last Benefit Month, staff must ensure that Form H1020 or Form TF0001 is sent to the household early enough to allow the household 10 calendar days to provide missing

information. They must still allow time for the final case action to be timely. Timeliness for desk reviews are calculated the same as if an interview was held.

Related Policy

Processing Redeterminations, B-122
Processing Untimely Redeterminations, B-124

B-130, Changes

Body

Revision 02-1; Effective January 1, 2002

See B-600, Changes, for procedures and time frames for processing changes.

B-140, Summary of Due Dates for Form H1020, Request for Information or Action

Body

Revision 25-3; Effective July 1, 2025

All Programs

The due date and final due date entries are in the following table. **Note:** If the 10th or 30th day falls on a non-business day, the due date is the next business day.

TANF

EDG Action	Due Date	Final Due Date
Application	10 days	• 30 days; or • 10th day if 10 days end after 30th day
Redetermination	10 days	10 days
Incomplete redetermination, including the addition of a household member	10 days	10 days

SNAP

EDG Action	Due Date	Final Due Date
Application	10 days	• 30 days; or • 10th day if 10 days end after 30th day
Untimely redetermination, including the addition of a household member	10 days	• 30 days; or • 10th day if 10 days end after 30th day
Timely redetermination, including the addition of a household member	10 days	• last business day of last benefit month; or • 10th day if 10 days end after last benefit month
Incomplete redetermination, including the addition of a household member	10 days	10 days

Medical programs, including Emergency Medicaid, except TP 40

EDG Action	Due Date	Final Due Date
Application	10 days	• 30 days; or • 10th day if 10 days end after 30th day

EDG Action	Due Date	Final Due Date
Redetermination	10 days	• 30 days or by the last day of the last benefit month of the current certification period, whichever is later; or • 10th day if 10 days end after 30th day **Note:** If the renewal packet is returned with less than 30 days left in the certification period, the final due date is the end of the month the renewal is processed.
Incomplete redetermination, including the addition of a household member	10 days	10 days

TP 40

EDG Action	Due Date	Final Due Date
Application	10 days	• 15 business days; or • 10th day if 10 days end after 15th business day
Redetermination	10 days	• 30 days or by the last day of the last benefit month of the current certification period, whichever is later; or • 10th day if 10 days end after 30th day **Note:** If the renewal packet is returned with less than 30 days left in the certification period, the final due date is the end of the month the renewal is processed.

B-150, Avoiding Invalid Denials Related to Missing Information and Missed Appointments

Body

Revision 23-4; Effective Oct. 1, 2023

All Programs

Ensure correspondence is sent to the person's current address. Update the person's address if a new address is reported on an application form or if there is a pending change of address.

Deny an EDG for failure to furnish information only if:

- the due date on Form H1020, Request for Information or Action, has expired;
- the information was requested on Form H1020; and
- there is confirmation that the requested information is not in the office such as the front desk, mail room, fax machine or imaged and available through the **State Portal**. Follow local procedures for locating submitted verifications.

Do not deny an EDG for missed appointment if:

- the denial date falls before the final due date listed on Form H1020 for applications and timely redeterminations;
- the agency failed to mail Form H1830-FA, Application/Review/Expiration/Appointment Notice, or Form H1020-MA-FA, Request for Information or Action-Missed Appointment-Flexible Appointment ; or
- the person files another application after missing the initial appointment date on Form H1830-FA and before the date provided on Form H1020-MA-FA. Follow policy to determine if the new application should be considered a duplicate application.

SNAP Denial Reminders (PDF)

Related Policy

Receipt of Duplicate Application, A-121.2

B-160, SNAP Timeliness Charts for Applications and All Redeterminations

Body

Revision 22-4; Effective Oct. 1, 2022

SNAP

Use the charts in this section as a guide to determine the date applicants must complete an appointment and HHSC must provide benefits for the case action to be reported as timely. The charts detail required actions and due dates in the following type situations:

- applications and untimely redeterminations;
- timely redeterminations after a regular certification period; and
- timely redeterminations after a short certification period.

SNAP Applications and Untimely Redeterminations

If	then
• the household completes an interview through the initial cold call attempts; • the household completes an interview on or before the date provided on Form H1830-FA, Application/Review/Expiration/Appointment Notice-Flexible Appointment; • the household completes an interview on or before the 30th day, and the application is not pended for verification; or • the household completes an interview on or before the 30th day, and the application is pended for verification and verification is provided timely on or before the 30th day;	• if eligible, ensure the household has an opportunity to participate by the 30th day after the file date; or • if not eligible, deny the application by the 30th day after the file date. **Note**: If the 30th day is a non-business day, take appropriate action the following business day.
• the household completes an interview on or before the 30th day after the file date and the application is pended for verification with a Form H1020, Request for Information or Action, due date before the 30th day and the household fails to provide verification timely; or • the household does not complete an interview by the date provided on Form H1830-FA and the 30th from the file date;	deny the application on the 30th day after the file date. **Note**: If the 30th day is a non-business day, take appropriate action the following business day.
the household does not complete an interview on or before the date provided on Form H1830-FA but completes an interview on or before the 30th day, and the application is pended for verification with a Form H1020 due on or after the 30th day and the household provides verification before the 30th day;	dispose by the 30th day: • if eligible, ensure the household has an opportunity to participate by the 30th day; or if not eligible, deny the application by the 30th day.
the household does not complete an interview on or before the date provided on Form H1830-FA but completes an interview on or before the 30th day, and the application is pended for verification and the household provides it timely on or after the 30th day;	dispose on the day the verification is provided. If the household is: • eligible, ensure the household has an opportunity to participate on the day verification is provided; or • not eligible, deny the application on the day verification is provided.
the household does not complete an interview on or before the date provided on Form H1830-FA but completes an interview on or before the 30th day, and the application is pended for verification with a Form H1020 with a due date on or after the 30th day and verification is not provided timely;	deny the application on the business day after the Form H1020 due date.
the household does not complete an appointment on or before the date provided on Form H1830-FA and does not complete an interview by the 30th day;	deny the application on the 30th day after the file date. **Note**: If the 30th day is a non-business day, take appropriate action the following business day.

Timely SNAP Redeterminations After a Regular Certification Period

If	then
• the household completes an interview through the initial cold call attempts; • the household completes an interview on or before the date provided on Form H1830-FA; • the household completes an interview on or before the last business day of the certification period, and the application is not pended for verification; or • the household completes an interview on or before the last business day of the certification period, and verification is provided timely on or before the last day of the certification period;	• if eligible, approve the redetermination application by the last business day of the certification period; or • • if not eligible, deny the redetermination application by the last business day of the certification period. **Note**: If the last day of the certification period is not a business day, take action the last business day before the end of the certification period.
the household does not complete an interview on or before the date provided on Form H1830-FA and does not complete an interview by the last business day of the certification period.	deny the application on the last business day of the certification period.
the household does not complete an interview on or before the date provided on Form H1830-FA but completes an interview before the last business day of the certification period, and the application is not pended for verification;	dispose the recertification application on the day the household completes the interview.
the household does not complete an interview on or before the date provided on Form H1830-FA but completes an interview on or before the last business day of the certification period, and the application is pended for verification with a Form H1020 and the household provides verification timely.	• if verification was provided by the last business day of the certification period, process by the last business day of the certification period; or • If verification was provided by the Form H1020 due date but after the certification period: ◦ if eligible, ensure the household has an opportunity to participate within five business days after receipt of the verification; or ◦ if not eligible, deny the application within five business days after receipt of the verification.
the household does not complete an interview on or before the date provided on Form H1830-FA but completes an interview on or before the last business day of the certification period, and the application is pended for verification with a Form H1020 and the household fails to provide verification by the final due date;	• if the Form H1020 due date was before the last business day of the certification period, deny the application on the last business day of the certification period; or • if the Form H1020 due date was on or after the last business day of the certification period, deny the application on the business day following the due date on Form H1020.

Timely SNAP Redeterminations After a Short Certification Period

If	then
• the household completes an interview through the initial cold call attempts; • the household completes an interview on or before the date provided on Form H1830-FA; • the household completes an interview on or before the 30th day after the last month's full benefit issuance, and the application is not pended for verification; or • the household completes an interview on or before the 30th day after the last full month’s issuance, and the application is pended for verification and verification is provided timely on or before the 30th day after the last month's full benefit issuance;	• if eligible, process the redetermination by the 30th day; or • if not eligible, deny the application by the 30th day. **Note**: If the 30th day is not a business day, take action on the last business day before the 30th day.

If	then
• the household does not complete an interview by the date provided on Form H1830-FA and does not complete an interview by the 30th day after the last month's full benefit issuance.	deny the application on the 30th day. **Note**: If the 30th day is a non-business day, take appropriate action the following business day.
the household does not complete an interview by the date provided on Form H1830-FA and completes an interview on or before the 30th day after the last month's full benefit issuance, and the application **is pended** for verification with a Form H1020 and the household provides verification timely;	• if verification was provided by the 30th day after the last month's full benefit issuance, process by the 30th day; • if verification was provided by the Form H1020 due date but after the 30th day after the last month's full benefit issuance: ◦ if eligible, ensure the household has an opportunity to participate within five business days after receipt of the verification; or ◦ if not eligible, deny the application within five business days after receipt of the verification.
• the household completes an interview on or before the date provided on form H1830-FA and the application is pended for verification with a Form H1020 and the household fails to provide verification by the final due date; or • the household does not complete an interview on or before the date provided on Form H1830-FA but completes an interview on or before the 30th day after the last month's full benefit issuance, and the application is pended for verification with a Form H1020 and the household fails to provide verification by the final due date;	• if the Form H1020 due date was before the 30th day after the last month's full benefit issuance, deny the application on the 30th day; or • if the Form H1020 due date was on or after the 30th day, deny the application on the business day following the due date on Form H1020.

B-170, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must document the reason(s) for delays in processing an application and advisor action as explained in B-113, Delay in Processing Applications.

For missed telephone interviews, advisors must document on the Appointment – Details page the time of each call when attempting to contact the applicant according to policy in B-114, Missed Appointment; B-122, Processing Redeterminations; and B-124, Processing Untimely Redeterminations.

Related Policy

The Texas Works Documentation Guide

B-200, Issuing Benefits

B-210, General Policy

Body

Revision 22-3; Effective July 1, 2022

TANF

The Texas Health and Human Services Commission (HHSC) issues Temporary Assistance for Needy Families (TANF) benefits via Electronic Benefit Transfer (EBT) on a Lone Star Card or warrant. The agency issues all one-time benefits via warrant.

Related Policy

Medicaid Eligibility, A-800
Issuing OTTANF Benefits, A-2451
Issuing One-Time TANF for Relatives Payments, A-2452

SNAP

HHSC issues all Supplemental Nutrition Assistance Program (SNAP) benefits by EBT using a Lone Star Card.

B-220, Benefits

Body

Revision 05-2; Effective April 1, 2005

B—221 Types of Benefits

Revision 23-3; Effective July 1, 2023

TANF and SNAP

There are seven types of benefits:

- initial;
- disaster;
- ongoing;
- supplemental;
- retroactive;
- replacement; and
- restored.

B—222 Mailing Addresses for Issuing Benefits

Revision 21-4; Effective October 1, 2021

TANF and Medical Programs

Staff issue benefits to the person's physical address, unless the person:

- is temporarily living at another address;
- has a post office box or general delivery address;
- has a guardian; or
- provides a good reason for a different mailing address, showing the person would suffer hardship if benefits were mailed to their physical address.

Staff should not use a local eligibility determination office address or an employee's physical address as a mailing address, unless the employee is the TANF applicant or recipient.

SNAP

The person's physical address is the preferred mailing address to enter in TIERS. However, the person may use another mailing address if they believe it is more secure or they have no physical address.

All Programs

Notes:

- If a person has a post office box and physical address, both are entered in TIERS, unless they reside in a shelter for battered persons.
- The U.S. Postal Service does not forward TANF warrants or the Your Texas Benefits Medicaid cards.

B-230, Electronic Benefit Transfer (EBT)

Body

Revision 23-3; Effective July 1, 2023

TANF and SNAP

HHSC issues benefits by EBT and contracts with one or more vendors who perform EBT functions.

When interview staff certify a household, HHSC establishes and deposits benefits in the household's EBT account(s). EBT issuance staff issue a Lone Star Card to the recipient or their representative. These cardholders access benefits using the card with a Personal Account Number (PAN) and a Personal Identification Number (PIN).

The EBT process includes:

- establishing a primary cardholder (PCH) and EBT account(s);
- establishing a secondary cardholder (SCH), if requested;
- issuing a Lone Star Card;
- pending card registration or allowing the household to select a PIN;
- replacing a card, if required; and
- providing a card sleeve, Form H1184, Here is Your Lone Star Card, and Form H1185, Important Information About Your Lone Star Card.

Related Policy

Establishing a Secondary Cardholder, B-232
Issuing a Lone Star Card, B-233
PIN Selection, B-234

B-231 Establishing the Primary Cardholder (PCH)

Revision 23-3; Effective July 1, 2023

TANF and SNAP

The PCH is the head of household (HOH) with the primary responsibility of security and access to the household's benefits in the EBT account. Staff establish the HOH as the PCH, even if the person is a disqualified member.

The HOH must act as the PCH except in the following situations:

- If the TANF Eligibility Determination Group (EDG) lists a protective payee or representative payee, establish this person as the PCH.
- If a SNAP recipient lives as a resident in a drug and alcohol (D&A) treatment or group living arrangement (GLA) facility, and the D&A or GLA facility acts as the person's authorized representative (AR), establish the facility AR as the PCH.

If the TANF and SNAP EDGs have...	then...
the same EDG name,	establish the HOH as the PCH for both EDGs. **Note**: Ensure that the name, date of birth, sex and Social Security number (SSN) match exactly.
different EDG names,	establish each EDG name as the PCH for the EBT account associated with their EDG.

To establish an EBT account, TIERS sends the new PCH record to the EBT system using real time interface or batch file. If the EBT system receives a benefit record before the PCH record, the EBT system uses the benefit record to create a PCH record. TIERS sends PCH records to the EBT system when staff:

- certify or pend a TANF or SNAP application; and
- change an EDG name, including when:
  - adding, removing, or changing a TANF protective payee or representative payee; or
  - adding, removing, or changing the SNAP AR for a D&A or GLA facility. **Note:** Staff must update the alternate payee information in TIERS to change the PCH record for an AR in the EBT system.

Staff complete Part II of Form H1175, EBT Change Request, to change the PCH on a denied EDG or when TIERS cannot send the record due to automation problems.

Note: Do not send a PCH record when pending the TANF or SNAP application due to a missed appointment.
TIERS updates existing PCH records on active cases any time staff change the cardholder's biographical data or address and complete the **Issuance** Logical Unit of Work (LUW). The EBT system receives an overnight file from TIERS that updates the PCH record the next day.

To change the cardholder's biographical data in the EBT system, staff complete a modify request in the **EBT Details LUW** in TIERS. If the TIERS system is offline and the household meets same-day service issuance criteria, staff must complete Part II of the Form H1175.

Staff complete Part IV of Form H1175 to merge PCH records via the EBT system when a household's TANF and SNAP PCH record information fails to match.

Related Policy

Protective Payee, A-171
Who Is Not Included, A-222
Splitting and Merging Primary Cardholder Records, B-261.3
Drug and Alcohol Treatment (D&A) or Group Living Arrangement (GLA) Facilities, B-440

B-232 Establishing a Secondary Cardholder

Revision 26-3; Effective July 1, 2026

TANF and SNAP

The PCH can establish an SCH only after HHSC certifies the household's application.

Exception: If staff certify a person for one program and pend the other, the person may authorize a different SCH for each program's benefit account.

The PCH may authorize:

- an SCH for only one benefit account;
- a different SCH for each benefit account; or
- the same person as the SCH for both the cash account and the food account.

After certification, the PCH can add, remove or change an SCH by going to an HHSC local office.

To establish an SCH in an HHSC local office, the PCH must:

- bring the secondary cardholder to the office;
- complete Form SCR, Secondary Cardholder Request;
- give the form to EBT issuance staff; and
- provide proof of identity.

The PCH can also call the Lone Star Help Desk to request Form SCR to add an SCH. Interview staff must make sure Form SCR is completed and signed by both the PCH and the SCH before:

- completing Form H1172, EBT Card, PIN and Data Entry Request; and
- notifying EBT issuance staff to establish an SCH record in the EBT system and complete card issuance.

With supervisory approval in emergency situations, establish account access for an SCH if:

- the household needs to establish an SCH; and
- the PCH cannot complete and sign Form SCR for reasons such as age, death, disability, distance to an HHSC local office or inability to appoint an AR.

After supervisory approval, staff get a completed Form SCR signed by another responsible household member. If there are no other responsible household members, staff get a completed Form SCR from the AR, if previously established. If there are no other responsible household members nor an established AR, staff and supervisor sign below the SCH's signature and issue the card to the SCH. Document the emergency and inability of the PCH, responsible household member and AR to sign the Form SCR in the case record.

Related Policy

Prudent Person Principle, A-137
Questionable Information, C-920

B-232.1 Secondary Cardholder Established by the Lone Star Help Desk

Revision 26-3; Effective July 1, 2026

TANF and SNAP

A PCH may contact the Lone Star Help Desk any time after certification to add an SCH.

The Lone Star Help Desk mails Form SCR, Secondary Cardholder Request to the PCH when they receive a request to add an SCH. The PCH must complete and sign the form, get the SCH's signature, and return the form to the EBT vendor to authorize the SCH.

EBT vendor staff mail the SCH's Lone Star Card to the PCH after receiving the completed Form SCR. The PCH must give the card to the SCH. The SCH must contact the Lone Star Help Desk to authenticate their identity and complete card registration.

B-233 Issuing a Lone Star Card

Revision 23-3; Effective July 1, 2023

TANF and SNAP

Staff request Lone Star Card issuance in TIERS when:

- pending or certifying a SNAP or TANF application;
- establishing a new PCH record; or
- establishing an SCH in an HHSC local office.

If the household was mailed a card and instead picks up a card in an HHSC local office, cancel the mailed card. If the Lone Star Card is mailed or issued in-office to someone other than the PCH, pend card registration to require the PCH to authenticate their identity and select a PIN before using their Lone Star Card. Lone Star Cards issued directly to the cardholder in the HHSC local office do not require card registration if the PIN is selected on the PIN pad.

The cardholder should keep their Lone Star Card, even if the household no longer receives a monthly SNAP allotment. If the household meets eligibility for benefit issuance in the future, it allows them to quickly access their EBT account.

Issuing a Card When Pending the Application

When pending an application for more verification, request card issuance by vendor mail-out or in-office, as appropriate, and explain the following to the person being interviewed:

- The household must provide the requested information and be determined eligible for SNAP or TANF before HHSC deposits benefits into their EBT account.
- If the household does not already have a Lone Star Card, the vendor mails the card to the PCH with EBT training materials.
- The household receiving a Lone Star Card does not mean they meet eligibility for benefits or have access to benefits in the EBT account.
- The PCH must call the Lone Star Help Desk when they receive their Lone Star Card to complete card registration by authenticating their identity and selecting a PIN.
- After receiving a notice of eligibility, the person should call the Lone Star Help Desk, login to their Your Texas Benefits mobile app to manage their EBT account.

Note: If staff pend the application for verification of ID, request card issuance by vendor mail-out and pend card registration to require the PCH to authenticate their identity before using their Lone Star Card.

Issuing a Card in an HHSC Local Office

A TANF protective payee or representative payee and D&A or GLA facility PCHs must come to the office to be issued a Lone Star Card. If the TANF protective or representative payee cannot come to the office, staff may request a vendor mail-out and pend card registration.
When issuing Lone Star Cards in the office, EBT issuance staff must:

- verify through TIERS inquiry that staff conducted an interview;
- verify the person meets criteria for in-office issuance, or criteria for a replacement card;
- verify the identity of the person receiving the card;
- issue the Lone Star Card and training materials;
- register the Lone Star Card to the correct EDG number; and
- follow established security and reconciliation procedures.

Issuing a Card During a Phone Interview

If the household completes the interview by phone and the EBT LUW shows no available card for the EDG, staff request card issuance using the following table.

Issuing a Lone Star Card During a Phone Interview

If the household interviews by phone and is:	then:
• eligible for expedited SNAP benefits; or • interviewed on or after the 25th day after the file date for SNAP benefits,	inform the person of the option to pick-up their Lone Star Card in the HHSC local office.
• determined eligible at the interview; or • pended for missing information and does not meet the criteria in the box above,	inform the person that they will receive their Lone Star Card by mail.
• denied at the interview,	do not request card issuance.

Issuing a Card During a Home Visit

If staff complete the interview during a home visit, a Lone Star Card may be issued during or after the home visit. If issuing a card after a home visit, request card issuance by vendor mail-out and pend card registration. If issuing a card during a home visit, staff complete the steps in the following table.

Lone Star Card Issuance During the Home Visit

Step	Action
1	Interview staff check to see if HHSC previously issued a Lone Star Card. If so, write down the PAN and provide the household with the active card's PAN during the home visit .
2	Interview staff request card issuance from HHSC local office issuance staff by completing Part I of the Form H1172 , EBT Card, PIN and Data Entry Request.
3	HHSC local office issuance staff complete Part II of the Form H1172 and log out a Lone Star Card using Form H1173, EBT Card Issuance Log, ensuring an EBT card can be provided to the household during the home visit.
4	HHSC local office issuance staff sign the Form H1172, get the interviewer's signature on the Form H1172, and retain their own copy of the Form H1172 until the interviewer returns from the home visit.
5	During the home visit, interview staff ask the PCH, responsible household member or AR if the household has a Lone Star Card and PIN. • If the household has a Lone Star Card, then provide the PAN from the EBT LUW to confirm the PAN on the household's Lone Star Card matches the PAN associated with their EBT account. ◦ If the PANs match, the household should be able to access their benefits using their existing card. If the household needs to reset their PIN, they may contact the Lone Star Help Desk or access their Your Texas Benefits account. ◦ If the PANs do not match, complete Step 6. • If the household does not have a Lone Star Card, complete Step 6.
6	If interview staff provide the household with the Lone Star Card logged out on the Form H1173 during Step 2, interview staff must: • explain that the PCH must select their PIN contacting the Lone Star Help Desk or accessing their Your Texas Benefits account; • provide the household with Form H1184, Here is your Lone Star Card, and Form H1185, Important Information About Your Lone Star Card; • obtain the PCH, responsible household member or AR's signature in Part II of the Form H1172; and • return the completed Form H1172 to HHSC local office issuance staff.
7	If the household received a Lone Star Card during a home visit, HHSC local office issuance staff must receive a completed Form H1172 from interview staff the same day. If the household did not receive a Lone Star Card during a home visit, HHSC local office issuance staff must:

Step	Action
	• ensure interview staff returned the Lone Star Card to the HHSC local office the same day; • confirm the PAN number on the returned card matches the PAN number on their copy of the Form H1172; and • use the Form H1173 to log the card back into inventory.

Related Policy

PIN Selection, B-234
Lone Star Card Replacements, B-235
Special Certification Situations, B-240
Drug and Alcohol Treatment (D&A) or Group Living Arrangement (GLA) Facilities, B-440
Residents in Family Violence Shelters, B-450
Prepared Meal Services, B-460

B-234 PIN Selection

Revision 23-3; Effective July 1, 2023

TANF and SNAP

In addition to the Lone Star Card, a cardholder must have a PIN to access benefits in the household's EBT account(s). The cardholder selects their PIN in the local office at card issuance or through the Lone Star Help Desk.

If the cardholder has a barrier that prevents them from selecting a PIN, they may request a pre-assigned PIN from the Lone Star Help Desk. The EBT vendor then mails the cardholder a PIN packet. The cardholder's statement about barriers that prevent them from self-selecting a PIN is acceptable.

After initial PIN selection or issuance, a cardholder may select a new PIN at any time by calling the Lone Star Help Desk or accessing their Your Texas Benefits mobile app.

Note: Lone Star Cards deactivated because the wrong PIN was entered five times in one day are reactivated automatically at midnight.

Related Policy

Special Certification Situations, B-240
EBT Vendor-Produced Materials, B-280
Drug and Alcohol Treatment (D&A) or Group Living Arrangement (GLA) Facilities, B-440
Residents in Family Violence Shelters, B-450
Prepared Meal Services, B-460

B-235 Lone Star Card Replacements

Revision 24-3; Effective July 1, 2024

TANF and SNAP

An EBT vendor or HHSC replaces a Lone Star Card when a cardholder:

- has an open EBT account; and
- cannot access the account because the person’s Lone Star Card was lost, stolen or does not work properly.

If a PCHor ;SCH reports a lost, stolen or not working Lone Star Card, the EBT vendor mails a replacement card to the PCH's TIERS address within two calendar days of the request. If the TIERS address is not current, the Lone Star Help Desk refers the person to 2-1-1 to update the household’s mailing or issuance address.

In certain situations, the HHSC local office replaces Lone Star Cards. The same policies and procedures for replacing cards for PCHs apply to the secondary cardholders except the PCH must go with the secondary cardholder to the HHSC local office to authorize the replacement.

When a cardholder contacts the HHSC local office to request a Lone Star Card replacement, determine the correct action using the chart below:

Replacement Card Criteria

If the card	then
does not work,	inquire on the EBT system and ensure the card is correctly connected to the account.
was lost or destroyed in a household disaster,	replace the card only if the household needs access to their account immediately and cannot wait for a replacement by mail from the Lone Star Help Desk.
is correctly connected to the account and lost, stolen or damaged,	refer the cardholder to the Lone Star Help Desk. The Help Desk cancels the person's Lone Star Card and sends a replacement by mail.* The cardholder can also freeze and unfreeze their Lone Star Card using their YourTexasBenefits.com account.
has unauthorized transactions,	replace the card and have the household select a new PIN only if the household has not requested a replacement card by mail through the Lone Star Help Desk or their Your Texas Benefits mobile app.

***Exceptions**: EBT issuance staff replace Lone Star Cards in the HHSC local office by the EBT system for cardholders, including Centralized Benefit Services (CBS) recipients, if the:

- Household is certified for a SNAP application that requires a priority issuance. Interview staff refer the person to EBT issuance staff for an immediate replacement.
- Person cannot get a replacement from the Lone Star Help Desk because the EBT system does not reflect the cardholder's correct biographical information or current mailing address.
- Household does not have a secure mailing address. A local eligibility determination office is not a secure mailing address for this purpose.
- Person has not received a requested replacement from the Lone Star Help Desk within seven calendar days after the order date reflected on the EBT system. EBT issuance staff must identify these replacements on Form H1173, EBT Card Issuance Log, by writing "VR" (Vendor Replacement) under the Replacement Column.

SNAP

To reduce trafficking, the EBT vendor tracks the number of replacement cards issued in a 12-month period. The EBT vendor sends a monthly report through an electronic interface to HHSC if a household requests four replacement cards within 12 months after the initial card issuance to a PCH or secondary cardholder. The print vendor sends the household a Notice TF0610, Notice of Excessive Card Replacements (PDF). Notice TF0610 advises the household that:

- they received four replacement cards in a 12-month period; and
- if the household requests a fifth replacement card, the Office of Inspector General (OIG) receives notification and may investigate their household.

The notice also gives a reminder of what constitutes trafficking.

Notice TF0610 directs households to contact 2-1-1 for any questions about the notice. Remind households inquiring about Notice TF0610 at HHSC local offices of appropriate Lone Star Card use and the penalties for trafficking.

The EBT vendor produces a monthly report for OIG identifying households that request a fifth replacement card.

Related Policy

Establishing a Secondary Cardholder, B-232
Benefit Issuance on Applications, B-252
Destroyed Food Replacements, B-344

B-236 PIN Replacements

Revision 24-4; Effective Oct. 1, 2024

TANF and SNAP

If the cardholder reports they forgot their PIN or that the PIN was compromised, refer the cardholder to the Lone Star Help Desk or their Your Texas Benefits mobile app to select a new PIN. If the cardholder cannot self-select a PIN after two attempts through the Lone Star Help Desk, they can transfer to an operator who can:

- provide training or assistance in the PIN self-selection process; or
- mail a PIN packet to the PCH's address if the person has a barrier that prevents them from self-selecting a PIN.

If the cardholder cannot self-select a PIN because their biographical data is incorrect in the EBT system, the Lone Star Help Desk refers the person to 2-1-1 to correct their biographical data.

Related Policy

EBT Material Inventory or Distribution, B-280

B-237 PCH Replacements

Revision 23-3; Effective July 1, 2023

TANF and SNAP

When benefits remain in an EBT account and the PCH, other responsible household member or AR is not able or available to access the benefits, staff may use the following table to determine when they may establish a new PCH.

Determining a New PCH

Step	Question	Action
1	Did the only household member with account access die, is absent temporarily, become incapacitated or abandon the child?	• If no, stop. Take no further action. • If yes, go to Step 2.
2	Is there another responsible household member who may be established as the PCH?	• If no, go to Step 3. • If yes, establish the other responsible household member as the PCH.
3	Is the child in the care of another person?	• If no, stop. Take no further action. • If yes, authorize account access to the new PCH using the procedures that follow in this section.

Related Policy

Issuing a Lone Star Card, B-233
PIN Selection, B-234
Lone Star Card Replacements, B-235

B-238 Reserved for Future Use

Revision 21-3; Effective July 1, 2021

B-239 Explaining Cardholder Responsibilities

Revision 21-3; Effective July 1, 2021

TANF and SNAP

HHSC must instruct the cardholder about their rights and responsibilities related to EBT.

B-239.1 Explanation of Cardholder Responsibilities at Interview

Revision 24-4; Effective Oct. 1, 2024

TANF and SNAP

Instruct the cardholder to read Form H1185, Important Information About Your Lone Star Card (PDF). Ask the cardholder questions about any EBT issuance procedures the cardholder does not understand. Also explain:

- Procedures for Lone Star Card issuance and PIN selection to access benefits including:
  - primary cardholder (PCH) and secondary cardholder, including how to establish a secondary cardholder;
  - how access is limited to a person with both the card and the PIN;
  - that there is no charge for using the Lone Star Card for food account purchases; and
  - that to get benefits they need to have a card, PIN and available benefits.
- Timeframes for their initial benefits, if certified, explaining the availability of monthly benefits as specified in Form H1184, Here Is Your Lone Star Card (PDF).

- Methods for how to use the Lone Star Card including how to:
  - make a purchase or cash withdrawal for TANF;
  - check the account balance;
  - identify stores accepting Lone Star Cards;
  - ask store personnel if the store provides TANF cash-back services; and
  - find the TANF cash-back policy.
- Security for Lone Star Cards, including:
  - how to keep benefits secure;
  - what to do if a card is lost or stolen or the PIN is compromised; and
  - that HHSC will not replace benefits used before a card is reported lost or stolen to the Lone Star Help Desk.
- A cardholder may still access benefits in their EBT account unless the benefits are expunged due to inactivity.
- Procedures for moving out of Texas including the:
  - use of the Lone Star Card to access TANF or SNAP benefits at retailers in other states; and
  - recommendation to withdraw all available cash benefits from the cash account before leaving the state.

A benefit conversion warrant, which can only be a full month's TANF benefit, may be mailed to the household's new address if the:

- cardholder cannot find a retailer that accepts the Lone Star Card; and
- the household moved out of state on or after the first of the month but before accessing that month's TANF benefits.

Related Policy

Issuing a Lone Star Card, B-233
PIN Selection, B-234
Cancelling Benefits in EBT Accounts, B-331
Moves Out of State, B-351
Expunged Benefits, B-370

B-239.2 Issuance Staff Requirements for Client Training

Revision 21-4; Effective October 1, 2021

TANF and SNAP

After receiving a request authorizing an initial Lone Star Card for the PCH, EBT issuance staff take the following actions:

- Issue and briefly explain the:
  - Lone Star Card;
  - card sleeve;
  - Form H1184, Here Is Your Lone Star Card; and
  - Form SCR, Secondary Cardholder Request.
- If issuing the Lone Star Card to someone other than the PCH, explain how to use each item to the person receiving the card.
- Explain:
  - the importance of saving the last receipt for the current account balance(s);
  - pending card registration, if required;
  - the requirement for the PCH to sign the back of the card;
  - how to protect the card and what to do if it is lost or stolen; and
  - how to protect the PIN and what to do if it is compromised.
- Advise the person to call the toll-free Lone Star Help Desk at 800-777-7EBT or 800-777-7328 if they have questions or problems accessing benefits.

B-240, Special Certification Situations

Body

Revision 21-4; Effective October 1, 2021

TANF and SNAP

Follow the procedures in this section for households with special needs.

Related Policy

Drug and Alcohol Treatment (D&A) or Group Living Arrangement (GLA) Facilities, B-440
Residents in Family Violence Shelters, B-450

Prepared Meal Services, B-460

B-241 Reserved for Future Use

Revision 21-4; Effective October 1, 2021

B-242 Reserved for Future Use

Revision 21-4; Effective October 1, 2021

B-243 Centralized Benefit Services (CBS) Cases

Revision 24-4; Effective Oct. 1, 2024

SNAP

Local office staff must not attempt to:

- issue benefits on a CBS case;
- make other changes to a CBS case; or
- make changes to any biographical data on a CBS case.

When local office staff dispose a case that has a SNAP-Combined Application Project (SNAP-CAP) EDG, the system does not allow the disposal of the CBS EDG. A task is generated for CBS staff to dispose the CBS EDG on the same day.

Related Policy

PIN Selection, B-234
Lone Star Card Replacements, B-235
PIN Replacements, B-236

B-243.1 Centralized Benefit Services (CBS) Case Changes

Revision 22-3; Effective July 1, 2022

SNAP

Regional office staff must not attempt to:

- issue benefits on a CBS case;
- make other changes to a CBS case; or
- make changes to the biographical data of a CBS case.

When regional staff dispose a case with an associated SNAP-Combined Application Project (SNAP-CAP) EDG, TIERS does not allow regional staff to dispose the CBS EDG. A TLM task generates for CBS staff to dispose the CBS EDG on the same day. If the person loses SSI benefits, the EDG is no longer considered a SNAP-CAP EDG and non-CBS staff can dispose the case action.

B-244 Homeless

Revision 21-4; Effective October 1, 2021

TANF and SNAP

Staff must advise homeless households to come to the local office if they require a Lone Star Card or PIN issuance or replacement.

SNAP

Homeless households may use SNAP benefits to purchase prepared meals.

Related Policy

Prepared Meal Services, B-460

B-245 SNAP Applications Filed with the Social Security Administration (SSA)

Revision 24-4; Effective Oct. 1, 2024

SNAP

Follow procedures for phone interviews and ensure the household has a Lone Star Card.

Related Policy

Interview Procedures, A-130
Issuing a Lone Star Card, B-233

B-250, EBT Benefit Issuance

Body

Revision 05-4; Effective August 1, 2005

TANF and SNAP

HHSC credits benefits to the cash or food account by sending a benefit record to the EBT system. This section describes the availability of those benefits for use by the cardholder.

B—251 Monthly Benefit Issuance Schedule

Revision 23-4; Effective Oct. 1, 2023

TANF and SNAP

HHSC sends the files of benefit records for monthly issuances to the EBT system after cutoff each month.

TANF

TANF monthly benefits issued via EBT are available on a staggered basis over the first three days of the month, based on the last number in the EDG number.

Table: Monthly TANF Benefit Issuance Date

Last digit of TANF EDG number	Day
0, 1, 2, 3	1
4, 5, 6	2
7, 8, 9	3

SNAP

Based on the last two digits of the EDG number, households receive their monthly benefits on a staggered basis from the 1st through the 28th day of the month.

If the household's benefits are pro-rated at application, the pro-rated benefit amount and the following monthly allotment may be issued as one deposit into the household's EBT account.

Note: SNAP benefits cannot be issued more than 40 days after the previous issuance. Households with applications certified more than 40 days before their scheduled monthly benefit issuance date have an initial issuance adjustment period until their benefits align with their scheduled monthly benefit issuance date.

SNAP households certified before May 1, 2023, keep their existing issuance schedule based on the date benefits were initially certified, unless there is a break in benefits of at least six months and the household reapplies after May 1, 2023.

Table: Monthly SNAP Benefit Issuance Date

Last two digits of the SNAP EDG number	Day
00-03	1

Last two digits of the SNAP EDG number	Day
04-06	2
07-10	3
11-13	4
14-17	5
18-20	6
21-24	7
25-27	8
28-31	9
32-34	10
35-38	11
39-41	12
42-45	13
46-49	14
50-53	15
54-57	16
58-60	17
61-64	18
65-67	19
68-71	20
72-74	21
75-78	22
79-81	23
82-85	24
86-88	25
89-92	26
93-95	27
96-99	28

B—252 Benefit Issuance on Applications

Revision 21-4; Effective October 1, 2021

TANF and SNAP

Staff provide benefits according to timeliness standards. Benefit issuances for certified applications are available immediately upon being credited to the account. Benefits requested after cutoff for the next month are available on the first day of the next month, except for SNAP-combined allotments.

SNAP

Staff may issue EBT SNAP benefits very quickly in situations that meet the HHSC criteria for a priority issuance. Request priority issuances only for SNAP benefits in three situations:

- expedited applications;
- regular applications certified on or after the 25th day; and
- benefits ordered by a hearing officer decision that requires a priority issuance to meet timeliness requirements.

The system credits benefits to the person's account in about an hour.

Related Policy

Deadlines, B-112

B—253 Methods for Sending Benefit Records

Revision 21-4; Effective October 1, 2021

TANF and SNAP

A benefit record may be sent two ways to the EBT system. TANF benefit records are sent only from TIERS. SNAP benefit records are normally sent only from TIERS, but priority issuances may also be sent by manual EBT system entry.

Entries are sent to TIERS through:

- Real time interface – credits the account right away; or
- Overnight batch file – credits the account by the next day.

Note: Manual EBT system entry must have supervisor approval.

When interview staff certify an application, the EBT system credits:

- SNAP priority issuances to the individual's account within one hour after EDG disposition; and
- TANF benefits and SNAP benefits that are not priority issuances to the individual's account by 8 a.m. CST (Central Standard Time) the day after the EDG is disposed.

B—254 Benefit Issuance When TIERS Is Unavailable

Revision 21-4; Effective October 1, 2021

TANF and SNAP

Two types of "TIERS unavailable" cases are:

- TIERS Down – TIERS is completely unavailable and the application or case cannot be accessed.
- TIERS Read-Only – TIERS is in read-only mode and workers cannot make changes to the EBT LUW for benefit issuance.

When TIERS is Down or is Read-Only, staff must:

- perform the interview;
- manually complete essential information on appropriate handbook forms;
- provide the client with manual notice;
- enter information into TIERS once it becomes available; and
- issue benefits or deny the case based on the household's eligibility.

B—255 Priority Issuances Using the EBT System

Revision 23-3; Effective July 1, 2023

SNAP

To send the primary cardholder's (PCH's) benefit record by the EBT system data entry process for priority issuances if TIERS is down or read-only, interview staff must:

- obtain the person's signature on Form H1855, Affidavit for Nonreceipt or Destroyed Supplemental Nutrition Assistance Program(SNAP) Benefits;
- complete Form H1172, EBT Card, PIN and Data Entry Request, to provide issuance staff the PCH's information for manual EBT system data entry;
- receive approval from the supervisor and the EBT regional coordinator to request manual EBT system benefit issuance; and
- notify issuance staff to complete the manual EBT system benefit issuance.

EBT regional coordinators must reconcile EBT system benefit record entries.

B—256 Discrepancies on Benefit Records Sent via the EBT System

Revision 21-4; Effective October 1, 2021

SNAP

When there is a discrepancy between the benefit records in TIERS and the EBT system, staff use the following chart to determine how actions are processed in TIERS and the EBT system:

If the benefit amount reported to TIERS is ...	then ...
more than the amount authorized in the EBT system,	the EBT system updates the household's benefit account to reflect the amount reported in TIERS.

If the benefit amount reported to TIERS is ...	then ...
less than the amount authorized in the EBT system,	TF-07E-01, EBT Reconciliation Exception Report, is produced and sent to management for distribution.

Related Policy

TF-07E-01, EBT Reconciliation Exception, B-262.5

B-260, EBT System

Body

Revision 21-4; Effective October 1, 2021

TANF and SNAP

The Electronic Benefit Transfer (EBT) system is a direct access web-based program. Staff, other than the issuance staff, must request card issuance in TIERS or complete Form H1175, EBT Change Request, to authorize action in the EBT system.

B—261 EBT System Functions

Revision 21-2; Effective April 1, 2021

TANF and SNAP

Designated staff use the EBT system to perform authorized functions. Since there are multiple functions that can be performed using the EBT system, there are multiple levels of access secured by individual sign-on IDs.

B—261.1 Issuing a Lone Star Card or Enabling PIN Self-Selection

Revision 21-4; Effective October 1, 2021

TANF and SNAP

EBT issuance staff use the EBT System to issue Lone Star Cards or enable PIN self-selection when:

- establishing a new PCH;
- replacing a Lone Star Card or PIN; or
- establishing a secondary cardholder in the local office.

B—261.2 Creating a Cardholder Record

Revision 21-4; Effective October 1, 2021

TANF and SNAP

Staff request EBT card issuance in TIERS or complete Form H1172, EBT Card, PIN and Data Entry Request, to establish a primary cardholder record via the EBT system.

B—261.3 Splitting and Merging Primary Cardholder Records

Revision 21-4; Effective October 1, 2021

TANF and SNAP

EBT regional coordinators use the EBT system to split PCH records when EBT accounts are incorrectly linked.

EBT accounts may be incorrectly linked when staff fails to reassign the EDG name to the current head of household from the previous one. As a result, the EBT system links the both EDGs belonging to two different people under one account.

Staff complete Form H1175, EBT Change Request to request that a EBT regional coordinator separate the incorrectly linked accounts.

EBT site and regional coordinators use the EBT system to merge PCH records when the EBT system cannot link them because of discrepancies in the cardholder's biographical data.

Discrepancies may occur in the cardholder's biographical data when staff do not correctly match the name, date of birth (DOB), sex, or SSN on a person's TANF and SNAP EDG numbers. As a result, the EBT system cannot merge the two PCH records into one record with a link to both accounts and a merge is required to allow individual access to both benefits on the same EBT card.

If the person wants to use one card to access both accounts, staff complete Form H1175 to authorize the merge. When the cardholder has one card for the cash account and another for the food account before the merge, the EBT system user indicates which card the person wants to use. After completing the merge, the EBT system automatically disables the card not chosen, and it must be destroyed.

B—261.4 Updating a Primary Cardholder Record

Revision 21-4; Effective October 1, 2021

TANF and SNAP

EBT issuance staff use the EBT system to update the PCH record. This can happen when the current PCH passes away and the PCH record needs to be updated to the current head of household.

Staff complete Form H1175, EBT Change Request, to authorize the PCH record update via the EBT system.

B—261.5 Creating a SNAP Benefit Record

Revision 21-4; Effective October 1, 2021

SNAP

HHSC limits the direct entry of SNAP benefit authorization in the EBT system when TIERS is unavailable, preventing the timely issuance of priority SNAP benefits.

Staff must request EBT card issuance to authorize benefit data entry into the EBT system following established sign-off procedures.

EBT regional coordinators complete EBT system data entry only after receipt of Form H1175.

B—261.6 Performing EBT System Inquiry

Revision 21-4; Effective October 1, 2021

TANF and SNAP

Designated local office staff use the EBT system to perform benefit record inquiry or to validate that a Lone Star Card is active. Staff view the **EBT Card Details** page to confirm if there is a previously issued Lone Star Card associated with the EDG.

EBT regional coordinators use the EBT system to perform transaction history inquiry.

B—261.7 Changing an EDG Number

Revision 18-1; Effective January 1, 2018

TANF and SNAP

EDG numbers cannot be changed, but multiple EDGs can be entered and connected to the same card.

B—261.8 Pending Card Registration

Revision 21-4; Effective October 1, 2021

TANF and SNAP

Staff pend the Lone Star Card registration during card issuance and in the EBT system when:

- issuing a card to someone other than the PCH; or
- mailing a card.

B—262 Reconciliation

Revision 21-4; Effective October 1, 2021

TANF and SNAP

This section provides general information about reconciliation. For details, see the *Security and Accountability Handbook* and the *Eligibility Operations Procedures Manual (EOPM) Appendix: EBT Procedures Manual*.

B—262.1 Reconciling EBT System Benefit Records to Forms H1175

Revision 21-4; Effective October 1, 2021

SNAP

Each day EBT staff designated in Local Office Security Plan (LOSP) prints the local EBT Report. This report contains a list of benefit records manually entered on the EBT system, sorted by employee identification number. A designated person must check these entries against Form H1175, EBT Change Request, on a daily basis to ensure accuracy.

B—262.2 Reconciling Benefit Records

Revision 21-4; Effective October 1, 2021

SNAP

Each day EBT staff use the list of benefit issuances on the EBT Report to reconcile the EBT benefit record entries with Form H1175, EBT Change Request. Within five days, state office staff send exception reports (TF-07E-01/TG-37E-1) to field offices to clear within established time frames.

To avoid exception reports, EBT issuance staff must ensure that interview staff report issuances via TIERS within three working days.

B—262.3 Reconciling EBT Card Issuances

Revision 21-4; Effective October 1, 2021

TANF and SNAP

Each day, designated staff use the list of card issuances on the EBT Report to reconcile cards issued in the region.

If the office has problems reconciling these, staff report the problem to the supervisor and the EBT regional coordinator to complete reconciliation.

B—262.4 TF-36, More Than One SNAP Benefit Authorized

Revision 21-4; Effective October 1, 2021

SNAP

After all issuances for a benefit month have been reconciled, state office generates the TF-36 report to display duplicate benefit issuances. Management reviews each SNAP EDG listed on the report to determine how the duplicate issuance occurred:

- individual error;
- suspected fraud;
- coding error; or
- whether the household correctly completed Form H1855, Affidavit for Nonreceipt or Destroyed Food Stamp Benefits, before the duplicate issuance.

If there is an overpayment and ...	then...
a signed Form H1855,	submit Form H4834, Individual or Recipient Provider Fraud Referral/Status Report, with the original Form H1855 to the regional Office of Program Integrity, Claims Investigation.
no signed Form H1855,	initiate a nonfraud recovery.

Related Policy

How to File an Overpayment Referral, B-730

B—262.5 TF-07E-01, EBT Reconciliation Exception

Revision 21-4; Effective October 1, 2021

SNAP

When an EBT issuance cannot be reconciled with the TIERS database, state office staff generate and send a TF-07E-01 to the supervisor of the employee who processed the last case action. This report serves as the clearance document to report case findings and actions taken.

Staff check the case record to determine:

- the reason for the reconciliation exception; and
- whether the amount of benefits provided to the household is correct.

If the amount of benefits is incorrect because of an ...	then...
overpayment,	initiate recovery.
underpayment,	restore benefits.

Related Policy

How to File an Overpayment Referral, B-730
Restored Benefits, B-800

B—263 Security

Revision 21-3; Effective July 1, 2021

TANF and SNAP

Only authorized staff with special permissions can enter data in the EBT system. Staff are designated by office. They must ensure that all information remains confidential.

The level of user access is determined by the individual user's sign-on ID. Designated employees have authorizations that allow updates to all or part of the system. Other users have inquiry access only.

B-270, Management of Automation Processes

Body

Revision 21-4; Effective October 1, 2021

TANF and SNAP

The EBT regional coordinator for each region reviews information for each user on a monthly basis.

B-280, EBT Material Inventory/Distribution

Body

Revision 21-4; Effective October 1, 2021

TANF and SNAP

An EBT vendor provides most EBT-related materials, including:

- Lone Star Cards;
- Lone Star Card mailers;
- Lone Star Card sleeves;
- Form H1184, Here Is Your Lone Star Card;
- Form H1185, Important Information About Your Lone Star Card; and
- Form SCR, Secondary Cardholder Request.

To order items produced by the EBT vendor, designated local office staff complete a request for Lone Star Cards or materials and send it to the EBT regional coordinator for secure and non-secure items.

The EBT regional coordinator or authorized regional staff submit the order request to the EBT vendor.

B-300, Account Maintenance

B-310, General Policy

Body

Revision 13-3; Effective July 1, 2013

TANF and SNAP

After HHSC certifies an Eligibility Determination Group (EDG), the advisor uses specific procedures to maintain the Electronic Benefit Transfer (EBT) account and resolve problems.

For information about establishing accounts, see B-200, Issuing Benefits.

B-320, Reserved for Future Use

Body

Revision 13-3; Effective July 1, 2013

B-330, Cancelling Benefits

Body

B—331 Cancelling Benefits in EBT Accounts

Revision 23-3; Effective July 1, 2023

TANF and SNAP

When a Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) household moves out of state before the end of the month, cancel the next month's benefits.

TANF

When a TANF household moves out of state on or after the first day of the month but before that month’s benefit accessibility date, the cardholder can use the Lone Star Card to access benefits at retailers in other states.

If the cardholder cannot find a retailer that accepts the Lone Star Card, a benefit conversion warrant (full month's benefit amount only) may be mailed to the household's new address. Perform inquiry in the EBT system to determine if the household accessed that month's benefits.

When the agency receives the report of the move:

- deny the EDG; and
- advise the cardholder to withdraw the balance from the EBT account.

Actions for the Next Month's Benefits

If the household is ...	then ...
ineligible for the next month's benefits because the household left the state before the end of the previous month,	cancel the next month's benefits.
eligible for the next month's benefit but unable to use the Lone Star Card out of state,	cancel the next month's benefits and reissue with a conversion warrant to the new address.

Do not consider a benefit cancelled until TIERS inquiry confirms cancellation.

Follow policy for deleting months when cancelling benefits for a person whose months count toward a time limit.

SNAP

HHSC cannot cancel benefits in a food account on or after the accessibility date.

When the agency receives a report that the person moved out of state, determine if the move is temporary or permanent. If the move is permanent, deny the EDG.

The cardholder can use the Lone Star Card to access benefits at retailers in other states.

Use the **TIERS Benefit Issuance – Maintain EBT Benefits – EBT Cancellation** pages to cancel the next month’s benefits.

Do not consider a benefit cancelled until TIERS inquiry confirms cancellation.

Related Policy

Moves Out of Texas, A-740
Temporary Visits Out of Texas, A-750
Deleting Months When TANF Benefits are Cancelled or Recouped, A-2533.1
Explanation of Cardholder Responsibilities at Interview, B-239.1
Cancelling Benefits Not Used by EBT, B-332
Using Benefits Out of State, B-350
Documentation Requirements, B-390

B—332 Cancelling Benefits Not Issued by EBT

Revision 13-3; Effective July 1, 2013

TANF

If an individual returns a warrant,

- give the individual the original Form H4100, Money Receipt (PDF); and
- send the first copy of Form H4100, the warrant, and Form H1008-A, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-receipt of Warrant (PDF), explaining the reason for the returned warrant to Fiscal Management, Mail Code 3500.

B-340, Replacing Benefits

Body

Revision 23-3; Effective July 1, 2023

TANF and SNAP

HHSC issues benefits by warrant or EBT. Staff replace TANF warrants, TANF EBT benefits and SNAP EBT benefits only in certain situations.

Related Policy

Agency Replacements, B-341
One-Time Payment Replacements, B-342
Destroyed Food Replacements, B-344

B-341 Agency Replacements

Revision 23-3; Effective July 1, 2023

TANF and SNAP

HHSC designs the EBT systems and issuance procedures to minimize loss and theft of SNAP and TANF household benefits. HHSC is required to issue agency replacement benefits only if the loss occurred:

- after the household reports the Lone Star Card lost or stolen and HHSC or an HHSC contractor failed to cancel the household's Lone Star Card;
- because of an HHSC local office Lone Star Card issuance error; or
- because of an unlawful or other erroneous action on the part of HHSC or an HHSC contractor.

Related Policy

Documentation Requirements, B-390

B-341.1 Procedures for Issuing Agency Replacements

Revision 26-1; Effective Jan.1,2026

TANF and SNAP

If a person reports lost benefits from the household's EBT account, the Lone Star help desk staff will research the account credits and debits. They will refer the client to the HHS AES state office staff to determine if HHSC is liable for any loss of benefits that occurred. If the state office staff determines a replacement is due because of prohibited staff access or card issuance error, the replacement is authorized.

Staff contact the EBT regional coordinator If a loss occurs because of a card issuance error. The coordinator notifies the HHSC AES Lone Star Business Services (LSBS) mailbox.

HHSC does not replace benefits taken from the household's account due to skimming, cloning or other fraudulent methods.

Related Policy

Balance Disputes, B-382.2

B-342 One-Time Payment Replacements

Revision 23-3; Effective July 1, 2023

TANF

If a person reports a One-Time TANF or One-Time TANF for Relatives warrant (check) as lost, stolen or not received, check TIERS inquiry to see if the warrant was returned to Fiscal Management Services (FMS). The most common reason for non-receipt is a mismatched address. The U.S. Postal Service (USPS) will not forward TANF warrants. If necessary, update the person's address in TIERS.

When the USPS returns the warrant to state office, FMS staff check inquiry for a new address and immediately re-mail the check, if there is a new address.

If the person does not receive the warrant by the 10th day after HHSC mailed it, request a replacement warrant by sending the appropriate form to FMS:

- For One-Time TANF, send Form H1008-A, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-Receipt of Warrant. If using Form H1008-A, write "OTTANF" across the top of the form.
- For One-Time TANF for Relatives, send Form H1084, Certification for Warrants Lost, Destroyed, Stolen, or Not Received.

Exception: Send the form immediately if it is obvious a warrant was stolen or destroyed. For Form H1008-A, indicate under "Comments" the reason for the special processing request.

Require the recipient to sign the Form H1008-A or H1084 in the correct space to attest to their statement that they did not receive the warrant and if they receive the first warrant, they will return it to HHS.

Staff may:

- fax Form H1008-A or H1084 to FMS at 512-487-3400; or
- send Form H1008-A or H1084 by email by scanning and emailing to the HHSC Warrant Issuance mailbox.

Staff may call HHS Accounting Operations within FMS at 512-487-3435 to check on the status of the replacement request.

After receiving Form H1008-A or H1084, FMS:

- complete TIERS inquiry to verify warrant information and status; and
- obtain the warrant payment status from the Texas Comptroller.

B-342.1 Warrant Not Cashed

Revision 22-3; Effective July 1, 2022

TANF

If the USPS has not returned the warrant to FMS or the recipient has not cashed the warrant, FMS:

- notifies the Texas Comptroller to cancel the warrant;
- receives notification when the Texas Comptroller cancels the warrant; and
- issues a replacement warrant. The word "Replacement" is printed in the upper right corner above the warrant number on the face of the warrant. TIERS inquiry identifies replacement warrants in **Benefits Issuance** under **Issuance Status** as “Issued” and Benefit Type as “Replacement."

If the person reports receipt of the original warrant after staff send the replacement request form, call FMS at 512-487-3435 to discontinue the inquiry and replacement process. Instruct the person not to cash the warrant until FMS notifies staff that they have discontinued the replacement process.

B-342.2 Warrant Cashed

Revision 22-3; Effective July 1, 2022

TANF

If someone cashed the warrant, FMS sends the staff person requesting the replacement:

- a cover memo with instructions;
- a copy of the warrant;
- Form 6059-A, Determination of the Validity of a Forgery Claim; and
- Form 6059-B, Affidavit of Forgery.

Staff:

- investigate to determine if someone forged the recipient’s signature to endorse and cash the warrant; or
- investigate if the recipient received any amount of money or benefit from the cashed warrant by perhaps conspiring with others; and
- complete Form 6059-A to document the determination.

If staff determine the signature endorsing the warrant was ...	then staff ...
forged,	• complete Form 6059-B; • request that the recipient signs the form; and • return Forms 6059-A and B to FMS.
not forged,	send only Form 6059-A to FMS.

If it is not a forgery and the recipient is the one who endorsed the warrant, the process stops. The recipient is not eligible for a replacement warrant.

If the signature is a forgery:

- FMS sends the completed packet to the Texas Comptroller’s office for a final determination.
- The Texas Comptroller requests money back from the original cashing establishment.

- The Texas Comptroller notifies FMS that the cashing establishment has returned payment.
- FMS issues a replacement warrant.

Note: The cashing establishment has up to nine months to investigate and return the payment to the Texas Comptroller.

For issues or further instructions and information, staff may contact HHS Accounting Operations within FMS by:

- phone at 512-487-3435;
- fax at 512-487-3400; or
- email to the HHSC Warrant Issuance mailbox.

B-343 Reserved for Future Use

Revision 22-3; Effective July 1, 2022

B-344 Destroyed Food Replacements

Revision 23-4; Effective Oct. 1, 2023

SNAP

Replacements may be issued when food purchased with SNAP benefits was destroyed in a household disaster. To report that food has been destroyed in a household disaster, the HOH, a responsible household member or AR must go to an HHSC local office to complete a destroyed food replacement benefit request.

A household disaster may:

- impact one or more households; and
- be an event that results in food purchased with SNAP benefits being destroyed, such as: fire, flood, tornado, accident, power outage or other similar event.

A household disaster does not include damage or destruction resulting from events within the household's control, such as:

- pets or children;
- utility disconnection; or
- deferred household maintenance.

When a household reports destroyed food, verify the disaster and issue destroyed food replacement benefits unless the household:

- failed to report the loss within 10 days of discovering the destroyed food; or
- received a disaster benefit issuance in the same month as the replacement request.

Issue replacement benefits for the household's reported loss up to a maximum of the household's last monthly allotment. If the household's last monthly allotment included restored benefits, include the full value of the restored benefit with the replacement. Do not impose a limit on the number of destroyed food replacement requests.

Related Policy

Prudent Person Principle, A-137
Questionable Information, C-920

B-344.1 Procedures for Issuing Destroyed Food Replacements

Revision 24-4; Effective Oct. 1, 2024

SNAP

To issue destroyed food replacement benefits, take the following steps:

Step	Action
1	Require the head of household, responsible household member or AR to go to an HHSC local office and complete Form H1855, Affidavit for Nonreceipt or Destroyed Supplemental Nutrition Assistance Program (SNAP) Benefits, to request replacement of destroyed food. or

Step	Action
	Mail Form H1855 to get the person's signature if a responsible household member or AR cannot come to the HHSC office because of: • age; • disability; • distance to the HHSC office; or • inability to appoint an AR. Issue a replacement only when HHSC receives the completed and signed Form H1855 within 10 days of the request for replacement.
2	Verify the disaster and date by: • reviewing disaster waiver approval broadcast provided by HHSC; • contacting a collateral source; • receiving documentation from a community agency, such as the fire department or Red Cross; or • visiting the person's home.
3	Issue a replacement benefit via TIERS – **Benefit Issuance – Request Manual Issuance**. **Note**: Authorized staff receive a request to approve the issuance.

Related Policy

Prudent Person Principle, A-137
Questionable Information, C-920

B-350, Using Benefits Out of State

Body

Revision 18-1; Effective January 1, 2018

TANF

Texans who leave the state should be able to use the Lone Star Card to access TANF benefits at retailers in other states.

People from other states may use EBT cards to access TANF benefits at retailers in Texas. When local office staff receive inquiries, advise the cardholder to try the card at stores that accept EBT cards in Texas. If it does not work, advise the person to contact the help desk of the state that issued the card.

SNAP

Texans who leave the state can use the Lone Star Card to access SNAP benefits at retailers in other states.

People from other states may use their EBT cards to access SNAP benefits at retailers in Texas. When local office staff receive inquiries, advise the cardholder to try the card at stores in Texas that accept SNAP benefits. If it does not work, advise the person to contact the help desk of the state that issued the card.

B—351 Moves Out of State

Revision 13-3; Effective July 1, 2013

TANF

If the household reports a move or temporary absence from Texas, follow the policy in A-740, Moves Out of Texas, and A-750, Temporary Visits Out of Texas, to determine whether to consider the move temporary or permanent.

The cardholder should be able to use the Lone Star Card to access benefits at retailers in other states. Advise the individual of the following:

- Withdraw any amount of benefits remaining in the cash account before leaving.

- Take your Lone Star Card.

  Note: If the individual reports that the individual does not have a Lone Star Card, advise the individual to contact the Lone Star Help Desk.

- In order to use cash benefits that were not accessible before the move, try the card at stores that accept EBT in other states. Ask if the store charges a fee and the amount of the fee. Verify and accept any fees before completing the cash withdrawal.
- Call the Lone Star Help Desk at 1-800-777-7EBT (1-800-777-7328) if your Lone Star Card does not work. The Lone Star Help Desk assists the cardholder in finding an out-of-state retailer that accepts the Lone Star Card. **Note:** If the cardholder cannot find a retailer that accepts the Lone Star Card and moved out of state on or after the first of the month but before accessing that month's TANF benefits, HHSC may mail a benefit conversion warrant (full month's benefit amount only) to the household's new address. The Lone Star Help Desk will advise these cardholders to contact the local eligibility determination office. See B-331, Cancelling Benefits in EBT Accounts.

SNAP

If the household reports a move or temporary absence from Texas, follow the policy in A-740 and A-750 to determine whether to consider the move temporary or permanent.

The cardholder can use the Lone Star Card to access benefits at retailers in other states. Advise the individual of the following:

- Take your Lone Star Card.

  Note: If the individual reports that the individual does not have a Lone Star Card, advise the individual to contact the Lone Star Help Desk.

- In order to use SNAP benefits, try the card at stores that accept SNAP in other states.
- Call the Lone Star Help Desk at 1-800-777-7EBT (1-800-777-7328) if your Lone Star Card does not work. The Lone Star Help Desk assists the cardholder in finding an out-of-state retailer that accepts the Lone Star Card.

B—352 Households Shopping Out of State

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Cardholders can use the Lone Star Card out of state. As a result, some households may continue to use benefits without reporting an out-of-state move. Households receiving benefits in Texas who shop out of state consistently, without shopping in Texas, may no longer meet residency requirements. See A-740, Moves Out of Texas, and A-750, Temporary Visits Out of Texas.

B—353 Out-of-State Shopping (OSS) Reports

Revision 13-3; Effective July 1, 2013

TANF and SNAP

State office produces a Non-Border OSS Report and a Border OSS Report monthly. Both reports list Lone Star Card usage for households that:

- shopped out of state in the last 60 days;
- did not shop in Texas during that period; and
- have active EDGs.

The Border OSS Report lists households with Lone Star Card usage in states that border Texas (Arkansas, Louisiana, Oklahoma and New Mexico). The Non-Border OSS Report lists households with Lone Star Card use in states that do not border Texas.

State office sends the Non-Border OSS report to Eligibility Operations each month for appropriate action as a potential change in Texas residence. This data also is included in a combined Data Broker report if the OSS occurred in the prior 12 months.

The Border OSS Report is not sent to Eligibility Operations each month for clearance. The data is included in a combined Data Broker report if the OSS occurred in the prior 12 months. EDGs that appear on the Border OSS Report must be cleared at a complete action after a household submits an application or redetermination.

B—353.1 Advisor Action on OSS Report Activity

Revision 19-4; Effective October 1, 2019

TANF and SNAP

Clearing Non-Border OSS Report Activity at a Change Action

Send the household Form H1020, Request for Information or Action, requesting verification of the household's address.

Exception: Clearing Non-Border OSS activity as a change action is not required when the household's most recent OSS activity occurred in the:

- month prior to the periodic review month or in the periodic review month of the household's TANF Eligibility Determination Group (EDG); or
- next to last benefit month or last benefit month of the household's SNAP EDG.

Clearing Non-Border OSS Report Activity at a Complete Action

The household must provide verification of the household's address when:

- the most recent OSS activity occurred within six months of the current interview/desk review month; and
- the OSS activity listed in the report was not previously cleared.

The interview/desk review month is month zero.

Note: Act on any associated Medical Program(s) as appropriate.

After a household has been asked to provide verification of the household's address, take the following action.

If the ...	then ...
household provides verification of the household's address,	determine continued eligibility for all programs based on residency requirements.
household does not provide verification of the household's address,	deny the SNAP EDG and any associated TANF/Medical Program EDGs for failure to provide information.
agency receives returned mail with no forwarding address and the household cannot be located,	deny the SNAP EDG for failure to provide information and any associated TANF/Medical Program EDGs for unable to locate.

Clearing Border OSS Report Activity

The requirement to clear the Border OSS Report only applies at a complete action. This report must be cleared at a complete action when a household submits an application or redetermination and the OSS activity in the report makes the household's address questionable.

Example: A household living in Texas near the Arkansas border and shopping in Arkansas may not be questionable. A household living in Austin and shopping in Arkansas would be questionable.

When a household's address is questionable, follow the policy outlined above for clearing a Non-Border OSS Report Activity at a Complete Action. If necessary, send the household Form H1020, Request for Information or Action, requesting verification of the household's address.

B—354 Card Replacements for Cardholders Who Are Out of State

Revision 13-3; Effective July 1, 2013

TANF and SNAP

If a Texas individual who is out of state reports that the individual's Lone Star Card was lost or stolen, advise the individual to contact the Lone Star Help Desk at 1-800-777-7EBT (1-800-777-7328).

B-360, Reserved for Future Use

Body

Revision 22-1; Effective January 1, 2022

B-370, Expunged Benefits

Body

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Expungement is a process in which HHSC removes unused TANF or SNAP benefits from an EBT account and returns them to the state or federal government.

B—371 Expungement Policy

Revision 23-1; Effective Jan. 1, 2023

TANF

HHSC expunges TANF benefits if:

- the household does not access its cash account for one year; or
- benefits remain in an account past their availability period.

Note: If the TANF household does not access its cash account for one year, HHSC removes the entire balance.

SNAP

HHSC expunges:

- SNAP benefits remaining from a particular month's issuance when the:
  - household does not access the account for nine months; and
  - benefit was issued more than nine months before the expungement file is processed; or
- the entire food account when HHSC denies an entire household because of death.

HHSC mails Form H0599, Notice of Expungement, to households 30 days before the expungement of unused benefits. Form H0599 informs the household that unused SNAP benefits will be removed from their EBT account if they do not make a purchase using their Lone Star Card before the date listed on the notice.

B—372 Advisor Procedures for Expunged Benefits

Revision 20-4; Effective October 1, 2020

TANF and SNAP

Explain expungement policy to people who inquire about these benefits.

Except for death denials, inform people who dispute the expungement or believe it was in error that their dispute will be routed to the Regional EBT Coordinator for review. Within two business days of receiving the dispute, the Regional EBT Coordinator will inform the person of the outcome.

SNAP

Staff is responsible for expungements resulting from death denials.

If the expungement resulted from an erroneously processed denial, restore benefits within one business day of discovering the error. Using a manual issuance in TIERS:

- round the benefits down to the nearest dollar if the balance includes 49 cents or less; or
- round up if it includes 50 cents or more.

Related Policy

Expungement Policy, B-371

B-380, EBT Problem Resolution

Body

Revision 23-3; Effective July 1, 2023

TANF and SNAP

HHSC staff use the following policies to handle electronic benefit transfer (EBT) related inquiries from households and retailers.

B-381 Retailer Inquiries

Revision 23-3; Effective July 1, 2023

TANF and SNAP

Refer retailers who have EBT questions or need a manual voucher authorization to the Lone Star Retailer's Help Desk at 877-209-5339.

Refer retailers to the SNAP Retailer Service Center 877-823-4369 or the Food and Nutrition Service website for questions about the U.S. Department of Agriculture (USDA) Food and Nutrition Service (FNS) retailer authorization process.

B-382 Client Inquiries

Revision 26-1; Effective Jan. 1, 2026

TANF and SNAP

Refer a household to the Lone Star Help Desk at 800-777-7EBT or 800-777-7328 or to their Your Texas Benefits mobile app if the household contacts HHSC to request information about their EBT account and the question is not about eligibility. Households can call the Lone Star Help Desk or use their Your Texas Benefits account to manage their EBT account to:

- request replacement Lone Star Cards and personal identification numbers (PINs);
- view account transaction history, balances and upcoming deposits;
- freeze and unfreeze their account for theft prevention; and
- file a dispute with the Lone Star Help Desk because of a discrepancy with a retailer.

Note: Only the primary cardholder (PCH) can view the household's EBT account information in their Your Texas Benefits account.

A household has 90 calendar days from the date the error occurred in an EBT transaction to file a dispute with the Lone Star Help Desk and request an adjustment. The EBT vendor reviews the request and notifies the household of the vendor's determination. Within 10 business days the EBT vendor must:

- investigate the dispute;
- determine the household's eligibility for an adjustment;
- send the household a written notice informing them of the decision; and
- make the adjustment to the household's EBT account, if applicable.

If the household disagrees with the vendor's decision after receiving the written notice, they may contact the Lone Star Help Desk to request a second review.

The household has the right to request a fair hearing.

Related Policy

Advisor Procedures for Expunged Benefits, B-372
Balance Disputes, B-382.2
Fair Hearings, B-1000

B-382.1 Cardholder Problems Accessing Benefits

Revision 22-1; Effective January 1, 2022

TANF and SNAP

Contact the EBT site coordinator when after card issuance:

- Benefits show in TIERS, but not in the EBT system, and both the card and PIN appear to work properly.

- Benefits show in the EBT system with no benefit number, but the benefits do not show in TIERS.

B-382.2 Balance Disputes

Revision 26-1; Effective Jan.1, 2026

TANF and SNAP

Advise the household to call the Lone Star Help Desk at 800-777-7EBT or 800-777-7328 to request a replacement card and PIN if they report a balance dispute because of unallowed use on their EBT account.

Households must also report unallowed use of their benefits or card to the OIG.

Refer the household complaint to the Lone Star Help Desk if they report a balance dispute because of a retailer error.

Related Policy

Client Inquiries, B-382

B-382.3 Client Problems with Retailers

Revision 23-3; Effective July 1, 2023

TANF and SNAP

Forward a complaint to the HHSC AES LSBS Mailbox when a person reports any problem with a retailer, other than a balance dispute .

B-382.4 Client Problems with an EBT Vendor

Revision 23-3; Effective July 1, 2023

TANF and SNAP

Forward the complaint to the HHSC AES LSBS Mailbox when a person reports a problem with an EBT vendor or the Lone Star Help Desk.

B-390, Documentation Requirements

Body

Revision 22-3; Effective July 1, 2023

TANF and SNAP

Document the reason for:

- cancelling benefits; and
- replacing benefits.

Related Policy

Canceling Benefits in EBT Accounts, B-331
Agency Replacements, B-341
Documentation, C-940
The Texas Works Documentation Guide

B-400, Special Households

B-410, Students in Higher Education

Body

Revision 13-4; Effective October 1, 2013

B—411 General Policy

Revision 15-4; Effective October 1, 2015

SNAP

A student in higher education is one who is enrolled at least half-time (as defined by the institution) in a college or university curriculum that offers degree programs, regardless of whether a high school diploma is required for admittance, or at a business, technical, trade or vocational school that normally requires a high school diploma or equivalent for admittance.

Student higher education policy does not apply to individuals:

- under age 18 (students are 18 the month after the student's 18th birthday);
- age 50 or older (students are 50 the month of the student's 50th birthday);
- enrolled in curricula (such as beauty school or auto mechanics) that do not require a diploma or the equivalent for entrance; or
- enrolled only in English as a second language curriculum.

Enrollment begins the first day of the first school term. For example, a high school senior might be accepted by a college and register for classes before graduation; however, the Texas Health and Human Services Commission (HHSC) does not consider the student enrolled until the first day of the college term.

Once enrolled, HHSC considers the student enrolled through vacation and recess, until the student graduates, is expelled, drops out, or does not intend to register for the next usual term, excluding summer school. A student remains enrolled between terms, breaks, and during summer vacations unless the student does not intend to return to school the next term.

B—412 Student Eligibility Requirements

Revision 26-1; Effective Jan. 1, 2026

SNAP

A student qualifies for the Supplemental Nutrition Assistance Program (SNAP) if the student meets at least one of the following:

1. Unfit for employment. If not evident, proof is required from a certified doctor or psychologist, or receipt of permanent or temporary disability benefits issued by government or private sources must be verified.
2. Employed for pay an average of 20 hours a week. If self-employed, the student must work an average of 20 hours a week and earn at least the federal minimum hourly wage.
3. Participating during the regular school year in a state or federally funded work study program. The student must be working at a job for pay or for dollar credits against tuition charges. This does not include students who must work for academic requirements, such as interns and student teachers. The student exemption starts the month the school term begins or the work study is approved to begin, whichever is later. The student exemption stops:

- if the student quits working, unless it results solely from lack of work study funds; or
- when there is a break between terms of a full calendar month or longer unless the student continues work study during the break.

4. Enrolled in school through one of the following programs:

- Workforce Innovation and Opportunity Act (WIOA);
- Choices;
- SNAP Employment and Training (E&T);
- Trade Adjustment Assistance, a program administered by the Texas Workforce Commission; or
- other state and local government training programs approved by state office as equivalent to E&T.

5. Participating in an on-the-job training program, classroom study is not considered on-the-job-training for this purpose.
6. Approved for Temporary Assistance for Needy Families (TANF).
7. Responsible for the care of a dependent child who is a certified household member and the child is:

- under 6 years old;
- at least 6 but under 12, and the student states there is no other available child care, which prevents the student from attending class and complying with work requirements in numbers 2 or 3 above.

Note: Both parents or caretakers cannot get student eligibility by caring for the same child, even if both are students.

8. A single parent, natural, adoptive or stepparent in the home or other single adult with parental control who is:

- enrolled full-time as determined by the school; and
- responsible for the care of a child under 12.

B—413 Ineligible Students

Revision 15-4; Effective October 1, 2015

SNAP

A student who does not meet the student eligibility requirements is not a member of the household. Do not count the student's income and resources for the remaining household members. If an ineligible student is also disqualified for another reason, the student is treated as a disqualified member.

If an ineligible student is also disqualified for another reason, the student is treated as a disqualified member. Advisors follow resource policy in A-1210, General Policy, and income policy in A-1362, Disqualified Members.

B—414 Work Registration

Revision 13-4; Effective October 1, 2013

SNAP

Eligible students are exempt from work registration during the regular school term. This exemption continues between terms, breaks and through scheduled school vacations for students who remain enrolled.

B—415 Verification Requirements

Revision 16-4; Effective October 1, 2016

SNAP

Staff must verify self-employment hours of students who work at least a weekly average of 20 hours and earn at least the federal minimum hourly wage. If the student does not provide verification by the due date, the student will be denied for failure to provide and is considered an ineligible student, unless they meet another student eligibility requirement as described in B-412, Student Eligibility Requirements.

B—416 Documentation Requirements

Revision 16-4; Effective October 1, 2016

SNAP

Advisors must document the student's eligibility, if questionable.

B-420, Other Special Situations

Body

Revision 13-4; Effective October 1, 2013

B—421 Food Distribution Program on Indian Reservations (FDPIR)

Revision 24-2; Effective April 1, 2024

SNAP

FDPIR is a food distribution program that provides commodity foods to low-income households living on an Indian reservation, and to Native American families living near reservations. The Indian tribe administers this program under approval from the Food and Nutrition Service (FNS). Households eligible for the FDPIR receive a monthly food package based on the number of household members. The following tribes are the only tribes approved to receive FDPIR in Texas:

- Alabama-Coushatta Tribe of Texas in Polk County; and
- Choctaw Nation of Oklahoma in Bowie, Fannin, Lamar, and Red River Counties.

A household cannot participate simultaneously in SNAP and FDPIR. An Indian Tribal Household eligible for both programs may participate in only one of the programs of its choice in a month. The household may switch from one program to the other, but benefits must be ended in one program before certifying the household for the other program. Benefits in the new program can be issued for the month after benefits end in the previous program.

B—421.1 Duplicate Participation

Revision 24-2; Effective April 1, 2024

HHSC staff must identify household members receiving duplicate benefits with SNAP and FDPIR. The household can be denied from either program. If duplicate participation occurs, a household overpayment occurs for the program that was certified for benefits last. HHSC staff must send an overpayment referral to the Office of Inspector General (OIG) if the overpayment occurred in SNAP.

The Livingston HHSC office receives a monthly list of certified FDPIR households in Polk County from the Alabama-Coushatta Tribe of Texas.

The Paris HHSC office receives a monthly list of certified FDPIR households in Bowie, Fannin, Lamar, and Red River from the Choctaw Nation of Oklahoma.

HHSC staff must:

- perform inquiry to identify any household members receiving benefits in both FDPIR and SNAP;
- notify FDPIR staff about any household member with duplicate participation; and
- deny SNAP, if appropriate, and refer the household to OIG for a SNAP overpayment.

Related Policy

How to File an Overpayment Referral, B-730

B—421.2 Intentional Program Violation (IPV)

Revision 13-4; Effective October 1, 2013

Any member disqualified from SNAP for an IPV is also disqualified from participating in the FDPIR program. Likewise, any member disqualified from FDPIR for an IPV is also disqualified from participation in SNAP for the full length of the IPV disqualification period. Advisors follow policy in B-940, Texas Works (TW) Responsibilities.

B—421.3 Switching from FDPIR to SNAP

Revision 24-2; Effective April 1, 2024

SNAP

Verify that the Indian Tribal Household does not receive FDPIR before determining SNAP eligibility by contacting FDPIR tribal staff.

Note: Alabama and Oklahoma are the only other states that can be entered in the Out of State Benefit Logical Unit of Work in this situation. Staff must document the facts in the Texas Integrated Eligibility Redesign System (TIERS) Case Comments.

B—421.4 Switching from SNAP to FDPIR

Revision 15-4; Effective October 1, 2015

SNAP

For Indian Tribal Households switching from SNAP to FDPIR, staff must:

- process the switch as a verbal request for voluntary withdrawal from SNAP;
- send Form TF0001, Notice of Case Action, allowing adequate notice;
- terminate SNAP benefits for the household as soon as possible so the household may be certified for FDPIR; and
- notify FDPIR staff of the SNAP denial effective date for the household.

Related Policy

Form TF0001 Required (Adequate Notice), A-2344.1

B—421.5 Verification Requirements

Revision 24-2; Effective April 1, 2024

SNAP

Verify that the Indian Tribal Household does not receive FDPIR and if there is a current FDPIR IPV before determining SNAP eligibility by contacting FDPIR tribal staff.

FDPIR tribal staff must contact the Livingston or Paris HHSC offices to verify the household does not receive SNAP or have a current SNAP IPV disqualification before certifying the household for FDPIR.

B—421.6 Documentation Requirements

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must document the:

- name and telephone number of the FDPIR staff who provides verification; and
- name of the household member currently disqualified for an IPV in FDPIR.

Related Policy

Documentation, C-940

B-430, Households with Elderly Members or Members with a Disability

Body

Revision 13-4; Effective October 1, 2013

B—431 Definition of Elderly

Revision 01-1; Effective January 1, 2001

SNAP

An elderly person is someone who is age 60 or older as of the last day of the month.

B—432 Definition of Disability

Revision 15-4; Effective October 1, 2015

SNAP

The following people are considered to have a disability:

- People approved for Supplemental Security Income (SSI), Social Security disability or blindness payments, or SSI Medicaid only.
- Veterans who receive Veterans Affairs (VA) benefits because they are rated a 100 percent service-connected disability or who, according to the VA, need regular aid and attendance or are permanently housebound.

- Surviving spouses of deceased veterans who meet one of the following criteria according to the VA:
  - need regular aid and attendance,
  - are permanently housebound, or
  - are approved for benefits from the VA because of the veteran's death and could be considered to have a permanent disability for Social Security purposes. (See B-432.1, Social Security's Criteria for Disability.)
- Surviving children (any age) of a deceased veteran who the VA:
  - determines are permanently incapable of self-support, or
  - approves for benefits because of the veteran's death and could be considered to have a permanent disability for Social Security purposes. (See B-432.1.)
- People receiving disability retirement benefits from any government agency for a disability that could be considered permanent for Social Security purposes.
- People receiving Railroad Retirement Disability who are also covered by Medicare.

B—432.1 Social Security's Criteria for Disability

Revision 15-4; Effective October 1, 2015

SNAP

The Social Security Administration (SSA) considers that any of the following 12 conditions result in permanent disability:

- Permanent loss of use of both hands, both feet, or one hand and one foot.
- Amputation of leg at hip.
- Amputation of leg or foot because of diabetes mellitus or peripheral vascular diseases.
- Total deafness, not correctable by surgery or hearing aid.
- Statutory blindness, unless caused by cataracts or detached retina.
- IQ of 59 or less, established after the person becomes age 16.
- Spinal cord or nerve root lesions resulting in paraplegia or quadriplegia.
- Multiple sclerosis in which there is damage to the nervous system caused by scattered areas of inflammation. The inflammation recurs and has progressed to varied interference with the function of the nervous system, including severe muscle weakness, paralysis, and vision and speech defects.
- Muscular dystrophy with irreversible wasting of the muscles, impairing the ability to use the arms or legs.
- Impaired renal function caused by chronic renal disease, resulting in severely reduced function which may require dialysis or kidney transplant.
- Amputation of a limb of a person at least age 55.
- AIDS progressed so that it results in extensive and/or recurring physical or mental impairment.

If the individual already receives SSI or Social Security blindness or disability payments, or the disability is obvious to the advisor (such as amputation of leg at hip), the advisor does not require additional verification. Other conditions may require the opinion of a physician. Advisors use Form H1836-A, Medical Release/Physician's Statement, in these instances.

B—433 Special Provisions for Households with Elderly Members or Members with a Disability

Revision 20-3; Effective July 1, 2020

SNAP

Households containing members who are elderly or who have a disability receive special treatment. The special provisions are:

- exemption from the gross income test;
- allowance of a deduction for medical expenses when the medical expenses exceed a total of $35 per month for all eligible members who are elderly or who have a disability; and
- allowance of an uncapped excess shelter deduction for the full monthly amount that exceeds 50 percent of the household's monthly income after the allowable deductions.

Exception: Households with members who are disqualified for not meeting SSN requirements, alien status requirements or for reaching ABAWD time limits are ineligible for an uncapped excess shelter deduction. Household members who are disqualified for another reason are eligible for the uncapped excess shelter deduction when there is a member of the household who is elderly or has a disability.

Related Policy

Income Limits and Eligibility Tests, A-1341
Medical Deduction, A-1428
Shelter Costs, A-1429
Deduction Amounts, C-121.1

B—434 Verification Requirements

Revision 20-3; Effective July 1, 2020

SNAP

Verify that a household member:

- is age 60 or older; or
- meets the disability criteria in B-432, Definition of Disability.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

B—435 Documentation Requirements

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must document:

- the reason the individual is considered to have a disability (see B-432, Definition of Disability);
- how age was verified (see B-431, Definition of Elderly); and
- how disability was verified (see B-432).

Related Policy

Documentation, C-940

B-440, Drug and Alcohol Treatment (D&A) or Group Living Arrangement (GLA) Facilities

Body

Revision 22-1; Effective January 1, 2022

B-441 Residents of D&A Facilities

Revision 22-1; Effective January 1, 2022

SNAP

People receiving chemical dependency treatment and residing in a facility that conducts a chemical dependency program may qualify for SNAP, regardless of the number of meals the facility provides, if the treatment facility is an approved institution. A D&A facility is an approved institution, if it is:

- certified as a retailer by the Food and Nutrition Service (FNS) to accept SNAP benefits; or
- a private, nonprofit organization or institution or a publicly operated community mental health center. To qualify under this provision, the facility or organization must also meet one of the following requirements:
  - be licensed by the Texas Department of State Health Services (DSHS) to operate a chemical dependency treatment facility; or
  - have written verification from DSHS that it is a registered faith-based exempt chemical dependency treatment program under Texas Health and Safety Code, Chapter 464, Subchapter C, and is recognized by DSHS as operating a program that furthers the purposes of Part B of Title XIX of the Public Health Service Act, the rehabilitation of drug addicts or alcoholics. The facility does not have to receive funds from DSHS.

Residents in D&A facilities that are not approved institutions may qualify for SNAP, only if the facility provides half of their meals or less. Consider this when determining if a person who resides in a facility is institutionalized.

Note: See disqualified persons policy for people disqualified due to felony drug conviction.

Evaluate all other eligibility criteria to determine whether a resident of the treatment center is eligible for SNAP.

Determine eligibility following the same income and resource policy as other households. Processing time frames and procedures for certifying households apply to residents of treatment facilities, except the following:

- Household size — Certify:
  - single residents of the treatment facility as separate one-person households; and
  - adult residents and their children as one household.
- Authorized representative (AR) — The treatment facility must act as the AR for all residents of the facility.
- Expedited service — Process the application to allow the resident an opportunity to participate by the seventh calendar day after the application date. The application date is day zero.
- Adverse action — When the facility loses its status as AR or loses its certification, the resident must be given adequate notice of adverse action.
- Work registration — The resident is exempt from work registration.

A facility that is no longer an approved institution (the facility loses its license from a state agency or the U.S. Department of Agriculture (USDA) disqualifies the facility as a retailer) cannot serve as an AR. Deny all existing SNAP Eligibility Determination Groups (EDGs) for residents in the facility. The facility may not debit residents' food accounts after the disqualification occurs.

Note: Refer the treatment center to the USDA FNS at 877-823-4369 or SNAP for inquiries about obtaining a SNAP retailer license from FNS.

Related Policy

Nonmembers, A-232.1
Disqualified Persons, A-232.2
Determining Whether a Person Who Resides in a Facility Is Institutionalized, B-490

B-442 Residents of GLA Facilities

Revision 22-1; Effective January 1, 2022

SNAP

A GLA is a public or private nonprofit residential facility that serves no more than 16 residents. People residing in a GLA facility may potentially qualify for SNAP, regardless of the number of meals the facility provides, if the GLA facility is an approved institution. A GLA is an approved institution if it is a:

- certified SNAP retailer; or
- nonprofit, certified by a state agency as required by Section 1616(e) of the Social Security Act.

Residents in GLA facilities that are not approved institutions may potentially qualify for SNAP, only if the facility provides half of their meals or less. Consider this when determining whether a person who resides in a facility is institutionalized.

Residents who meet disability definition criteria may be certified under group living arrangements. Determine eligibility according to the same income and resource standards as other households.

GLA residents may apply:

- for themselves;
- through an AR of their choosing; or
- through an AR employed by the facility.

If a member of the group wants to apply separately from other GLA residents, the facility makes the decision to allow the resident to apply separately based on the resident's physical and mental ability. Accept applications from any person the facility allows to apply as a one-person household or for any group of residents applying as a household.

Processing time frames and procedures for certifying households apply to GLA residents, except:

- Household size — If the resident applies using the facility as the AR, the resident is certified as a one-person household. If the residents apply without using the facility as AR, the largest allowable household size is 16.
- Expedited service — Provide benefits to allow the resident an opportunity to participate by the seventh calendar day after the application date. The application date is day zero.
- Adverse action — When the facility loses its status as AR or loses its certification, the resident is given adequate notice of adverse action.
- Work registration — Members must be registered unless exempt.

Related Policy

Nonmembers, A-232.1
Disqualified Persons, A-232.2

Determining Whether a Person Who Resides in a Facility Is Institutionalized, B-490

B-443 HHSC Responsibilities

Revision 13-4; Effective October 1, 2013

B-443.1 Staff Responsibilities

Revision 22-1; Effective January 1, 2022

SNAP

For residents participating in D&A or GLA facilities, verify that the D&A or GLA facility meets the eligibility criteria.

D&A or GLA facility eligibility certification may be verified by contract documents or certificates of eligibility from the USDA, HHSC or DSHS. Verify nonprofit status by reviewing a current, valid Internal Revenue Service (IRS) exemption or a document from the Texas State Comptroller of Public Accounts. If the facility is a USDA-certified retailer, the facility's eligibility is verified.

Provide the facility AR a copy of Form H1851, Reference Guide for Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities (PDF). The AR must acknowledge receipt of Form H1851 by signing Form H1846, Facility Authorized Representative Interview (PDF). Ensure the AR understands each of the facility's responsibilities.

Ensure the facility AR has a supply of Form H1852, List of Resident Participants in the Supplemental Nutrition Assistance Program (SNAP). The AR must return Form H1852 to HHSC by the fifth day of every month, or the following business day if the fifth is not a business day. Repeated failure to return this form is a program violation. Use Form H1852 to help monitor the facility's compliance with its responsibilities as AR. Complete and send Form H1847, Reminder to Submit Form H1852, when the facility report is three days past due.

Ensure the AR has a supply of Form H1019, Report of Change, and postage-paid envelopes.

On-site visits to the facility must be made at least once every six months.

During these visits, use Form H1845, Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facility Review (PDF), to document the:

- date of the visit;
- number of residents; and
- proof the facility continues to meet eligibility requirements.

Report suspected misuse of SNAP by the facility to the Electronic Benefit Transfer (EBT) regional coordinator. Use Form H1845 or Form H1853, Documentation of Findings (PDF), to report suspected misuse after evaluating the monthly Form H1852 returned by the facility.

Ensure the facility returns the correct benefit amount to the person's EBT account. If the facility is unable or unwilling to return the person's benefits:

- send Form H1096, Notification Letter (PDF), to advise the facility of the overpayment;
- email Form H1095, Treatment Facility Fraud Referral (PDF), to the Office of the Inspector General (OIG) Benefits Program Integrity (BPI) mailbox; and
- immediately restore improperly accessed benefits to the person.

Note: If a household managed by Centralized Benefit Services (CBS) moves into a D&A or GLA facility, update the Living Arrangement record to convert the EDG back to SNAP and out of the CBS caseload.

Maintain a D&A or GLA facility case file in the local office for each facility. Keep copies of any forms, reports or supporting documentation in this file.

Related Policy

Residents of D&A Facilities, B-441
Residents of GLA Facilities, B-442
Resident Moves Out of a D&A or GLA Facility, B-447

B-443.1.1 Monitoring Facilities

Revision 22-1; Effective January 1, 2022

SNAP

Information provided each month by facilities on Form H1852, List of Resident Participants in the Supplemental Nutrition Assistance Program (SNAP), must be monitored to ensure certified residents receive the correct amount of SNAP benefits.

Compare the information on the current month's Form H1852 to the information on the previous month's Form H1852 and clear any discrepancies. Consider the following questions in detail:

- Are the same residents certified?
- Did any of the residents move out during the month? If so:
  - Did the facility report the change and return the Lone Star Card within three business days?
  - Did the Lone Star account contain the correct benefit amount?
  - Was the EBT card accessed after the residents reported move out date?

If the facility fails to report residents who move out or fails to return the Lone Star Card, deny the EDGs following the D&A or GLA facility resident moves out procedure. Remind facilities of the responsibility as an AR to report moves and return the Lone Star Card within three days of the change. Complete Form H1853, Documentation of Findings, for monthly Form H1852, to document findings. If there are no findings, document no findings. Place a copy of the findings in the facility case file and provide a copy to the EBT regional coordinator responsible for the facility case file.

Related Policy

Resident Moves Out of a D&A or GLA Facility, B-447

B-443.2 EBT Regional and Site Coordinator Responsibilities

Revision 26-1; Effective Jan. 1, 2026

SNAP

EBT regional coordinators report misuse of SNAP benefits in facilities certified as retailers by the USDA. They do this by sending Form H1853, Documentation of Findings for Form H1852, to the HHSC AES EO State and Regional Operations mailbox.

State office makes referrals to the HHSC OIG BPI mailbox. If necessary, the USDA sends a copy to the EBT regional coordinator and after, notification of any action taken.

Do not take any further adverse action on a facility certified by USDA before USDA's action. Compute over-issuances for each resident, as appropriate.

If OIG staff confirms the report is valid, OIG refers the misuse to the USDA for its information and consideration for prosecution. The OIG sends a copy of the referral to the EBT site coordinator responsible for the facility case file and notifies the EBT regional coordinator of any action taken by USDA.

B-444 Overview of EBT Processes for Residents of D&A or GLA Facilities

Revision 22-1; Effective January 1, 2022

SNAP

Establish the AR as the primary cardholder (PCH) and issue a Lone Star Card to access a resident's benefits in the food account. Allow the AR to select a PIN through the Lone Star Help Desk or receive a vendor mailed PIN packet.

Some D&A or GLA facilities are certified by the USDA as SNAP retailers, and some are not. Regardless of SNAP retailer certification, the facility serves as AR and is responsible for the use of SNAP benefits of all residents who participate in SNAP (except for some GLAs). Benefits issued by EBT for residents of these D&A or GLA facilities are handled per one of the following three methods:

- An EBT vendor contracts with D&A or GLA facilities certified by USDA as SNAP retailers to process EBT transactions in two ways:
  - If the D&A or GLA facility processes a minimum monthly value of SNAP transactions, an EBT vendor installs Point of Sale (POS) equipment on site. The facility, as AR and PCH, debits the residents' SNAP benefits by swiping each resident's Lone Star Card through their POS equipment and entering the associated PIN. An EBT vendor completes the financial settlement to pay the retailer the day after a SNAP transaction is completed.
  - If the retailer processes less than the minimum monthly value of SNAP transactions to receive POS equipment, an EBT vendor contracts with the retailer to use a manual voucher system to process EBT SNAP transactions from each resident's account. An EBT vendor completes the financial settlement to pay the retailer the day after a SNAP transaction is completed.
- D&A or GLA facilities that are not USDA-certified retailers do not contract with an EBT vendor to accept SNAP benefits. However, if the facility meets the D&A or GLA eligibility criteria for non-USDA certified retailers, residents of those facilities can still participate in the SNAP program with the facility AR responsible for the residents' SNAP benefits. In this situation, the facility AR is established as the PCH, a Lone Star Card is issued, and the AR can select a PIN through the Lone Star Help Desk or receive a vendor mailed PIN

packet. The facility AR may use the food account, Lone Star Card and PIN to purchase food for the resident at a SNAP certified retail store or market.

- **Note:** GLAs do not always serve as AR for each resident. If the GLA employee is not listed as a GLA-AR on a resident's SNAP EDG follow normal EBT issuance procedures. The resident uses the Lone Star Card to purchase food from a regular retailer or to purchase prepared meals from the GLA if the GLA is certified as a retailer by USDA.

Related Policy

EBT Vendor-Produced Materials, B-280
Residents of D&A Facilities, B-441
Residents of GLA Facilities, B-442

B-445 D&A or GLA Facility Responsibilities as ARs

Revision 22-1; Effective January 1, 2022

SNAP

The D&A or GLA facility acting as AR must:

- apply for and provide accurate information on behalf of a resident;
- use the Lone Star Card to debit the resident's food account;
- buy and prepare food for eligible residents;
- buy meals delivered to each resident;
- report the loss of USDA or DSHS certification or loss of nonprofit status to HHSC within 10 days;
- report any changes, losses, over-issuances or misuse of SNAP benefits;
- provide departing residents Form H1019, Report of Change, as appropriate, and advise the person to report their new address within 10 days;
- report and return the Lone Star Card issued for departed residents to HHSC within three business days after the person moves out, whether announced or not;
- ensure the security of all Lone Star Cards and PINs issued to the facility AR;
- ensure the departing resident's Lone Star Card contains all the SNAP benefits that are unspent when the resident moves out; and
- return Form H1852, List of Resident Participants in the Supplemental Nutrition Assistance Program (SNAP), by the fifth day of every month, or the following business day if the fifth day is not a business day.

Both, the resident and facility AR must sign the application form.

The facility, acting as an AR, is liable if it knowingly commits a program violation to obtain SNAP benefits for a resident.

The facility must maintain a sufficient supply of required forms. Form H1852, Form H1019 and HHSC return envelopes may be obtained from HHSC and will be offered to the AR at each certification.

Related Policy

Use of SNAP Benefits by D&A or GLA Facilities Which Serve as SNAP Authorized Representative (AR), B-445.1

B-445.1 Use of SNAP Benefits by D&A or GLA Facilities Which Serve as SNAP ARs

Revision 22-1; Effective January 1, 2022

SNAP

HHSC restricts how the D&A and GLA facilities may use the resident's benefits. Inform the facility AR of these rules during the interview and provide them with Form H1851, Reference Guide for Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities.

Related Policy

Account Access, B-445.1.1
Returning Unspent Benefits When a Resident Moves Out, B-445.1.3
Residents Moving Out Before the 16th of a Month, B-445.1.4

B-445.1.1 Account Access

Revision 22-1; Effective January 1, 2022

SNAP

HHSC issues a Lone Star Card to the facility AR and enables the AR to select a PIN through the PIN pad in the local office or the Lone Star Help Desk. HHSC allows the AR access **only** to benefits issued for a month the person is a facility resident. The facility may assign one person to serve as the AR to apply for the resident and another to serve as AR or PCH and use the Lone Star Card.

Note: When the D&A or GLA facility is the AR, the facility is responsible for all benefits in an account. Therefore, security of the card and PIN is as important to them as it is to a person not in a facility.

HHSC is unable to issue benefits to the D&A or GLA facility AR for a month the resident is in the facility when that month's benefits were already issued to the resident's existing food account. If the resident wants to allow the facility access to previously issued benefits, the resident has the following options:

For facilities that are not USDA-certified retailers, the resident may:

- use the card to purchase groceries to give to the facility; or
- make the D&A or GLA facility AR a secondary cardholder on the existing account to access those benefits. To establish the facility AR as a secondary cardholder:
  - staff must ensure that the person made this choice and approved it; and
  - EBT issuance staff must establish the secondary cardholder, issue the card and pend card registration.

For facilities that are USDA-certified retailers, the resident can:

- use one of the options listed above for facilities that are not USDA-certified; or
- use the Lone Star Card to purchase meals via the facility POS device or via the EBT manual voucher process. The facility may only charge for prepared meals on a per day basis, not in advance. In addition, the facility **is not** allowed possession of the card previously issued to the resident, nor knowledge of the resident's PIN.

Related Policy

Application Processing for D&A or GLA Facilities, B-446

B-445.1.2 Reserved for Future Use

Revision 22-1; Effective January 1, 2022

B-445.1.3 Returning Unspent Benefits When a Resident Moves Out

Revision 22-1; Effective January 1, 2022

SNAP

When a resident moves out of the D&A or GLA facility, the facility must return all unspent benefits issued to the AR's account regardless of when the resident moves out, even if it means returning all the resident's benefits. D&A and GLA facilities are not allowed to spend a resident's benefits after the resident moves out.

After a resident moves out, the facility must return the AR's EBT card and ensure the account contains all unspent benefits. For purposes of this policy, "spent" means the facility used the EBT Card to access the resident's benefits before the person moved out.

If the facility accesses benefits that it is not allowed to use, the facility must return the benefits to the account. USDA-certified facilities can return benefits using the POS device to process a return on the account or via communication with an EBT vendor. Facilities not certified as retailers by USDA must ask a retailer to process a return on the resident's account using the AR's EBT card on the store's POS device.

If the retailer cannot restore benefits to the EBT card, initiate a claim against the facility by sending Form H1096, Notification Letter, and sending Form H1095, Treatment Facility Fraud Referral, to the OIG Benefits Program Integrity (BPI) mailbox and restore benefits to the person.

Related Policy

Restored Benefits, B-800

B-445.1.4 Residents Moving Out Before the 16th of a Month

Revision 22-1; Effective January 1, 2022

SNAP

The D&A or GLA facility must return at least half of the monthly allotment for residents who move out before the 16th of the month. Therefore, although a facility can access more than half of the monthly allotment before the 16th, it is not a best practice to do so.

The D&A or GLA facility AR know the full allotment amount from the person's notice. If the EDG has recoupment, staff must notify the facility AR to use the Lone Star Help Desk (800-777-7EBT) to verify monthly benefits.

D&A or GLA facilities without a POS device must be cautious to ensure they do not use more than half of a resident's monthly allotment before the 16th of the month, because they have no POS device to process a return if the resident moves out before the 16th of the month.

B-446 Application Processing for D&A or GLA Facilities

Revision 22-1; Effective January 1, 2022

SNAP

Process SNAP EDGs for residents in D&A or GLA facilities using one of the following procedures, depending on the resident's situation at application.

At the time of disposition, staff must review the **Issuance – Details** page and the **Alternate Payee – Summary** page, to ensure that TIERS successfully included the PCH record for the facility AR.

Note: TIERS does not collect biographical data on D&A or GLA facility ARs, so TIERS cannot send this information to the EBT system.

B-446.1 New Resident (or Denied Resident with No Benefits in an EBT Account) Who Moves into a D&A or GLA Facility and Applies for SNAP

Revision 22-3; Effective July 1, 2022

SNAP

- Interview staff:
  - interview the AR;
  - advise the AR about the limitations noted on Form H1851, Reference Guide for Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities;
  - provide EBT training material if the AR has not already received it;
  - send the PCH record for the facility AR to the EBT system by indicating in the TIERS issuance pages that there is an alternate payee. After the batch, complete Form H1175, EBT Change Request, to change the biographical information in the EBT system to the facility AR dispose the SNAP EDG; and
  - complete issuance.
- EBT issuance staff must:
  - issue a card to the AR;
  - print the EDG name in the space under the signature field on the back of the Lone Star Card; and
  - enable the AR to select a PIN through the Lone Star Help Desk.
- The facility AR uses the card and PIN to access benefits in the food account. **Note:** If the resident also receives TANF, the cash account is not available to the D&A or GLA facility AR. The resident has a separate card and PIN for the cash account.

Related Policy

Application Processing for D&A or GLA Facilities, B-446

B-446.2 Resident Has an Active SNAP EDG (or a Denied-Ongoing SNAP EDG), No Benefits in the Food Account, and All SNAP Household Members Move into the D&A or GLA Facility

Revision 22-1; Effective January 1, 2022

SNAP

Follow policy for a new resident who moves into a D&A or GLA facility. The D&A or GLA facility representative is added as AR for the existing SNAP EDG and the SNAP EDG is certified if it is currently denied.

Related Policy

New Resident (or Denied Resident with No Benefits in an EBT Account) Who Moves into a D&A or GLA Facility and Applies for SNAP, B-446.1

B-446.3 All Other Situations

Revision 22-1; Effective January 1, 2022

SNAP

Assign the resident a new SNAP EDG number and certify the resident using the new EDG number to establish a separate EBT food account as a resident of a D&A or GLA facility with a facility AR.

- If the resident is on an active SNAP EDG (and all members are not moving into the facility), remove the person from the existing EDG before certifying on a new case.
- If the resident is currently certified as a single person household on a previous case (but has a remaining benefit balance), certify the resident for SNAP with a certification period for the remaining months using a different case number. A new Form H1010, Texas Works Application for Assistance — Your Texas Benefits, is not required. The file date is the first day of the first month of the remaining certification period. Cross reference the other case in the TIERS **Case Comments** section of each case.

Enter the facility AR's information in the **Authorized Representative** page and indicate in the **Issuance – Details** page that there is an alternate payee. Complete the subsequent **Alternate Payee – Summary** page.

Request card issuance and provide a completed Form H1175, EBT Change Request, to EBT issuance staff. EBT issuance staff enter additional data to the PCH record for the AR through the EBT system for the new EDG number.

Related Policy

Application Processing for D&A or GLA Facilities, B-446
New Resident (or Denied Resident with No Benefits in an EBT Account) Who Moves into a D&A or GLA Facility and Applies for SNAP, B-446.1

B-447 Resident Moves Out of D&A or GLA Facility

Revision 22-3; Effective July 1, 2022

SNAP

Follow these procedures when the resident moves out of the facility:

- The facility AR:
  - notifies HHSC of the move; and
  - returns the Lone Star Card (in-person) for this account to the local office within three business days of the move.
- Check the account balance to ensure the D&A or GLA facility returned the correct benefit amount. Ensure the facility returns any benefit amount spent to the resident's food account after the resident moved out. Monthly benefits and account balance information are available on the EBT system benefit history screen. The EBT system transaction history screens provide information to verify if the AR debited the account after the resident moved out. Transactions are listed by date and time.
- Report violations according to staff responsibility policy.
- After ensuring benefits are properly returned, destroy the card according to procedures for returned Lone Star Cards.
- Follow procedure 1 or 2 below.

1. **If the facility reports the move and the former resident has not contacted HHSC:**
   - Send the EDG name to the EBT system as the new PCH. Complete of Form H1175, EBT Change Request, and send to EBT issuance staff, who will use the information to update the PCH record in the EBT system.
   - Immediately remove the AR entries including any designations in the **Issuance – Details** and the **Alternate Payee – Summary** pages and update the address, if known.
   - Document in **Case Comments** the name of the facility and facility AR that are being removed. Do not issue a new card and PIN until requested by the former resident.
   - Follow normal adverse action procedures to deny the EDG.

2. **If former resident reports the move to another D&A or GLA facility:**
   - Do not deny the existing active case.
   - Remove the former facility AR.
   - Document in Case Comments the name of the facility and facility AR that are being removed and the name of the new facility and facility AR that are being added and when.

- Enter the new facility AR's information in the **Authorized Representative** page and indicate in the **Issuance – Details** page that there is an alternate payee. Complete the subsequent **Alternate Payee – Summary** page.
- Request card issuance and enable the new AR to select a PIN through the Lone Star Help Desk.
- Complete Part II of Form H1175 and send to EBT issuance staff, who will use the information to complete the new PCH record on the new AR via the EBT system.
- EBT issuance staff:
  - issue a card to the AR;
  - report the PAN;
  - print the EDG name in the space under the signature field on the back of the Lone Star Card; and
  - enable the AR to select a PIN through the Lone Star Help Desk.

Follow these procedures if the former resident moves in with another active SNAP household and the former resident will participate with that household:

- Deny the active D&A or GLA case and send Form TF0001, Notice of Case Action, following regular adverse action procedures.
- Send the case name to the EBT system to change the PCH by removing all AR-related entries in TIERS, including any designations in the **Issuance – Details** and the **Alternate Payee – Summary** pages.
- Change the address to the resident's new address.
- Document in **Case Comments** the name of the facility and facility AR removed and the date. Cross reference the other case in the **Case Comments** section of each case.
- If there are still benefits in the account, complete a card issuance request to give the former resident access to the account and enable the person to select a PIN through the Lone Star Help Desk.
- If updating PCH biographical information, complete Part II of Form H1175 and send to EBT issuance staff, who will update the PCH record in the EBT system.
- Add the former resident to the other household's SNAP EDG effective the month after any final benefits are received.

Follow these procedures if the former resident moves and no longer lives in a D&A or GLA facility or does not participate with another active SNAP household. Move the former resident's remaining months of SNAP certification to a different case (and thus a new food account) and:

- Send the case name to the EBT system to change the new PCH on the currently active case by removing all AR-related entries in TIERS including any designations in the **Issuance – Details** and the **Alternate Payee – Summary** pages.
- Change the address to the resident's new address.
- Document in **Case Comments** the name of the facility and facility AR that are being removed and when.
- Deny the former resident's active SNAP EDG. Do not send notice of adverse action since benefits are not actually being denied.
- Certify the former resident for SNAP with a certification period for the remaining months using a different case number. If the former resident has a previous denied-ongoing case, use it and associate the case number during Application Registration. Do not require a new Form H1010, Texas Works Application for Assistance — Your Texas Benefits. The file date is the first day of the first month of the remaining certification period. Cross reference the other case in the **Case Comments** section of each case.
- Complete issuance request to give the former resident access to the account(s) by issuing a new card and enabling the person to select a new PIN through the Lone Star Help Desk.
- If updating PCH biographical information, complete Form H1175 and send to EBT issuance staff, who will update the PCH record in the EBT system.

Related Policy

Staff Responsibilities, B-443.1
Application Processing for D&A or GLA Facilities, B-446

B-448 D&A or GLA Facility Replaces the AR

Revision 22-3; Effective July 1, 2022

SNAP

To replace an AR, the D&A or GLA facility must provide a written request to HHSC.

Follow these procedures if a D&A or GLA facility replaces the AR. Do not replace Lone Star Cards for residents' accounts:

- Interview staff:
  - change the name of the AR on all applicable TIERS cases by replacing the former facility AR with the new person in the **Authorized Representative** page and the **Alternate Payee Summary** page;
  - document the change for each case and when the change occurred in **Case Comments**; and
  - complete Form H1175, EBT Change Request, for each case to update the existing PCH record with new AR name and biographical information; and
  - complete a new Form H1846, Facility Authorized Representative Interview, at the first certification following replacement of the AR.
- EBT issuance staff update the PCH record for each case in the EBT system and ensure the Form H1175 is included in each case record.

Related Policy

Application Processing for D&A or GLA Facilities, B-446

B-449 Verification Requirements

Revision 22-1; Effective January 1, 2022

SNAP

Verify the facility meets the D&A or GLA facility eligibility criteria.

Related Policy

Residents of D&A Facilities, B-441
Residents of GLA Facilities, B-442
Questionable Information, C-920
Providing Verification, C-930

B-450, Residents in Family Violence Shelters

Body

Revision 13-4; Effective October 1, 2013

B-451 Eligibility Requirements

Revision 22-1; Effective January 1, 2022

SNAP

People residing in a family violence shelter may potentially qualify for SNAP, regardless of the number of meals the shelter provides, if the family violence shelter is an approved institution. A family violence shelter is an approved institution if it is a:

- certified SNAP retailer; or
- public or private nonprofit facility.

Residents in family violence shelters that are not approved institutions may potentially qualify for SNAP, only if the facility provides half of their meals or less. Consider this when determining if a person who resides in a facility is institutionalized.

Residents in eligible family violence shelters may receive SNAP benefits as individual household units or as part of a group of individuals like any other household.

Residents in family violence shelters may apply for SNAP and use SNAP benefits on their own behalf. Residents may also appoint a shelter representative or another person to act as AR or secondary cardholder.

Residents in shelters must meet the same income and resource standards as other households. Resources held jointly with the abuser are considered inaccessible. Room payments to the shelter are considered shelter expenses. These households have the same rights to notices of adverse action, fair hearing, and lost benefits as other households. Residents should be registered for work unless otherwise exempt.

Normal processing standards for initial and ongoing eligibility decisions, handling reported changes and other actions and usual verification and documentation requirements apply to residents in shelters for battered persons.

Related Policy

Nonmembers, A-232.1
Determining Whether an Person Who Resides in a Facility Is Institutionalized, B-490

B-452 Approved Centers That Provide Meals

Revision 15-4; Effective October 1, 2015

SNAP

Family violence shelters that provide meals must be public or private nonprofit residential facilities that serve victims of family violence. If a facility serves other people, part of the facility must be set aside on a long-term basis to serve only family violence victims.

Advisors must verify the shelter's status as a nonprofit organization by seeing a current certificate from the IRS or a document from the Texas State Comptroller of Public Accounts. If the shelter is a USDA-certified retailer, the shelter's eligibility is verified.

B-452.1 Buying Meals

Revision 13-4; Effective October 1, 2013

SNAP

Individual households may use their SNAP benefits to buy meals prepared for them at a shelter that is a USDA-certified retailer.

B-453 Authorized Representatives

Revision 01-3; Effective April 1, 2001

SNAP

Employees of facilities that are USDA-certified retailers may not be authorized to serve as AR/secondary cardholders unless HHSC decides that there are no other representatives available.

If the shelter is not a USDA-certified retailer, the household may authorize a shelter representative as secondary cardholder.

B-454 Participation Twice in Same Month

Revision 10-4; Effective October 1, 2010

SNAP

A shelter resident can qualify for a duplicate SNAP benefit in a single month if:

- the resident's former household already received benefits for the month; and
- the resident's former household was based on a household size that included the resident, any children, and the person who abused or threatened to abuse them.

B-454.1 Duplicate Participation Procedures

Revision 24-4; Effective Oct. 1, 2024

SNAP

Remove the resident from the former household's case.

Special certification procedures based on entries made on the **Living Arrangements** logical unit of work (LUW) allow duplicate participation until the resident is removed from the former household. Establish a new SNAP case and food account if the person is the case name or has a Lone Star Card on the previous case. The person must complete a new Form H1010, Texas Works Application for Assistance — Your Texas Benefits (PDF).

If the person has not been removed from the former case:

- complete the certification process;
- issue the person a new Lone Star Card;
- pend card registration to enable the person to select a PIN through the Lone Star Help Desk; and
- issue benefits.

Related Policy

Issuing a Lone Star Card, B-233
PIN Selection, B-234
Benefit Issuance on Applications, B-252

B-460, Prepared Meal Services

Body

Revision 13-4; Effective October 1, 2013

B-461 Communal Dining or Meal Delivery Services

Revision 15-4; Effective October 1, 2015

SNAP

Eligible individuals and their spouses may use SNAP benefits to purchase prepared meals through communal dining or meal delivery services authorized by FNS.

To be eligible, a household member must:

- be age 60 or older;
- be housebound;
- have a physical disability;
- have a disability to the extent the member is unable to adequately prepare all meals; or
- be receiving SSI.

B-462 Prepared Meals for Homeless

Revision 12-2; Effective April 1, 2012

SNAP

Homeless individuals may use SNAP benefits to purchase prepared meals from meal providers authorized by FNS.

B-463 Staff Responsibilities

Revision 21-2; Effective April 1, 2021

SNAP

The Lone Star Card does not identify people qualifying for communal dining, meal delivery, or homeless people eligible for prepared meals. Use Form H1175, EBT Change Request, to send the primary cardholder (PCH) record and indicate in the endorsement box of Form H1175 either:

- Communal dining
- Meal delivery
- Homeless
- Every service

B-464 EBT Coordinator Responsibilities

Revision 15-4; Effective October 1, 2015

SNAP

If a meal-provider representative contacts HHSC about certification procedures, the advisor should refer the meal-provider representative to the EBT coordinator to approve these providers.

The EBT coordinator must ensure through discussion with the meal provider that the establishment:

- provides meals to homeless people, and
- is a public or private nonprofit organization as defined by IRS. HHSC may require the provider to present documentation from IRS to verify nonprofit status under §501(c)(3) of IRS regulations.

If the meal provider meets these requirements, the EBT coordinator will:

- obtain the meal-provider representative's signature on Form H1832, Affidavit for Meal Providers to the Homeless; and
- refer the provider to USDA, with the original, signed Form H1832, to apply for authorization as a retailer.

B-465 Matrix of Prepared Meals, Services, Households and Codes

Revision 15-4; Effective October 1, 2015

SNAP

Prepared Meals

SNAP Recipient	Communal Dining (Public or Nonprofit Private)	Meal Delivery	Homeless Meal Provider (Public or Nonprofit Private)
Age 60 or older, not homeless	XX	XX	
SSI recipient who is under age 60, not homeless	XX	XX	
Under age 60, not an SSI recipient, housebound, a person with physical disabilities, or has disabilities to the extent they are unable to adequately prepare own meals		XX	
Homeless only			XX
Homeless age 60 or older	XX	XX	XX
Homeless SSI recipient who is under age 60	XX	XX	XX
Endorsement status allowed to purchase from meal provider	Codes C,E	Codes C,M,E	Codes H,E

Codes:

C – SSI/elderly member authorized to purchase prepared meals from communal dining facilities or meal delivery services.

E – Homeless and either elderly or SSI household authorized to purchase from every service (communal dining, meal delivery services or homeless meal providers).

H – Homeless household authorized to purchase from homeless meal provider.

M – Housebound or a member with a disability authorized to purchase from meal delivery service.

B-470, Categorically Eligible Households

Body

Revision 05-5; Effective October 1, 2005

SNAP

Categorically eligible households are subject to fewer eligibility requirements than other SNAP households. HHSC uses special procedures to process applications from persons who potentially meet the categorical eligibility criteria. Categorical eligibility does not mean the applicants automatically receive SNAP.

B-471 Eligibility Criteria

Revision 15-4; Effective October 1, 2015

SNAP

SNAP households meet categorical eligibility criteria if:

- all members are approved for TANF cash assistance or SSI; or
- the household:
  - meets the resource criteria to be authorized to receive TANF Non-cash (TANF-NC) services (see A-1210, General Policy); and
  - has gross income less than or equal to 165 percent of the Federal Poverty Income Limit (FPIL) for its size.

This also includes households that have:

- active EDGs but whose benefits are being recouped; or
- a disqualified alien member or student who does not get TANF/SSI.

The household is not categorically eligible if:

- one or more members are disqualified from TANF or SNAP for an IPV; or
- the entire household is ineligible because the primary wage earner (PWE) failed to comply with E&T or voluntary quit requirements; or
- if the household is otherwise ineligible due to one or more members' disqualification for any reason.

For TANF-NC, a household is not categorically eligible if one or more members has a current SNAP IPV disqualification. If the household meets the combined resource limit of $5,000 for liquid assets and excess vehicle value, the household is still authorized to receive TANF-NC, and their remaining resources are exempt. The household is not exempt from the gross/net income limits.

B-472 Special Treatment for Households Meeting Categorical Eligibility Criteria

Revision 26-1; Effective Jan.1,2026

SNAP

Categorically Eligible TANF or SSI Households

Categorically eligible households are not subject to the resource and gross or net income limits. These households are exempt from verification requirements for:

- Social Security numbers (SSNs);
- resources;
- residence; and
- sponsored alien information.

Categorically Eligible TANF-NC Households

TANF-NC categorically eligible households are not subject to the resource or gross and net income limits. These households are exempt from verification requirements of:

- Social Security numbers;
- residence; and
- sponsored alien information.

Related Policy

General Policy, A-1210
Limits, A-1220
Prepaid Burial Insurance, A-1233.2
Vehicles, A-1238
How to Determine Fair Market Value of Vehicles, A-1238.5
General Policy, A-1310
Special Provisions for Households with Elderly Members or Members with a Disability, B-433

B-473 Application Processing

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must follow these procedures when processing a joint application for TANF and/or SSI and SNAP:

If the TANF/SSI application is pending and the household...	then ...
is eligible for SNAP without meeting categorical eligibility criteria,	certify the SNAP application as soon as possible. Follow normal SNAP time frames.
will not be eligible for SNAP unless the TANF or SSI application is granted,	delay denial of the SNAP EDG. Pend the SNAP application for up to 30 days awaiting the TANF/SSI decision. If the TANF/SSI application is denied on or before the 30th day, deny the SNAP application immediately. If the TANF/SSI application is granted by the 30th day, certify for SNAP as soon as possible. Prorate from the SNAP application date.

If the TANF/SSI application is pending and the household...	then ...
	If the TANF/SSI application is still pending by the 30th day: • deny the SNAP application; and • notify the individual on the denial notice to contact the certification office if the TANF/SSI is later granted. If the TANF/SSI application is granted after the 30th day: • copy Form H1010, Texas Works Application for Assistance — Your Texas Benefits, and return the original to the applicant (the applicant must initial any changes, re-sign Form H1010, and return it to the local eligibility determination office); • reopen the SNAP application when Form H1010 is returned; • verify and document any changes since the initial interview; and • prorate benefits from the original SNAP file date or the effective date of TANF/SSI benefits, whichever is later.*

* When prorating from the effective date of TANF/SSI benefits, use this date as the new SNAP file date. The effective date of benefits for TANF is the earlier of the certification date or 30 days after the file date. The effective date of benefits for SSI applicants is the:

- SSI file date; or
- date the individual met all eligibility criteria, if later than the file date.

Advisors must verify the SSI benefit effective date by viewing the award letter or by running Wire Third-Party Query (WTPY) or the State Online Query (SOLQ).

B-474 Centralized Benefit Services (CBS) Section

Revision 13-4; Effective October 1, 2013

SNAP and Medical Programs

CBS is a centralized section that processes certain types of cases statewide.

Related Policy

Specialized and Centralized Casework Units, C-1471

B-474.1 Programs Administered by CBS

Revision 13-4; Effective October 1, 2013

SNAP and Medical Programs

CBS administers SNAP and Medical Programs for several individual groups. For information concerning the SNAP Combined Application Project (SNAP-CAP), which is one of the programs that CBS administers, see B-475, Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP).

B-474.1.1 SNAP Programs

Revision 22-3; Effective July 1, 2022

SNAP

CBS administers SNAP for eligible SSI households as part of SNAP-CAP.

B-474.1.2 Medical Programs

Revision 26-3; Effective July 1, 2026

CBS administers medical programs for:

- children placed in or released from a Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) facility;
- former foster care children;
- women diagnosed with breast or cervical cancer; and
- people incarcerated in the Texas Department of Criminal Justice (TDCJ) who receive inpatient services.

Related Policy

Centralized Benefit Services, B-540

B—474.1.2.1 Reserved for Future Use

Revision 20-4; Effective October 1, 2020

B-474.1.2.2 Reserved for Future Use

Revision 20-4; Effective October 1, 2020

B-474.1.2.3 Medicaid for Transitioning Foster Care Youth

Revision 17-2; Effective April 1, 2017

Policy for TP 70 — Medicaid for Transitioning Foster Care Youth (MTFCY), is explained in Part M, Medicaid for Transitioning Foster Care Youth (MTFCY).

B-474.1.2.4 Former Foster Care in Higher Education

Revision 17-2; Effective April 1, 2017

Policy for type Assistance (TA) 77 — Former Foster Care in Higher Education (FFCHE), is explained in Part F, Former Foster Care in Higher Education (FFCHE).

B-474.1.2.5 Medicaid for Breast and Cervical Cancer

Revision 17-2; Effective April 1, 2017

Policy for TA 66 — Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive, and TA 67 — MBCC, is explained in Part X, Medicaid for Breast and Cervical Cancer (MBCC).

B-474.1.2.6 Former Foster Care Children

Revision 18-1; Effective January 1, 2018

Policy for TA 82 — Medicaid for Former Foster Care Children (FFCC), is explained in Part E, Former Foster Care Children (FFCC).

B-474.2 Conversion of EDGs

Revision 22-3; Effective July 1, 2022

SNAP

EDGs are converted to CBS when a household is eligible for SNAP-CAP.

After the local office completes an initial certification, an automated process converts EDGs that meet the criteria to CBS. The automated process occurs monthly at cutoff. HHSC mails the person a notice to inform them:

- that the EDG is handled by CBS, and
- to report household changes by:
  - calling 2-1-1;
  - entering the change in the Self-Service Portal; or
  - notifying HHSC via mail.

The notice includes contact information. Continue to accept changes and complete case actions until the EDG converts to CBS.

B-474.3 Methods of Reporting Changes

Revision 15-4; Effective October 1, 2015

SNAP and Medical Programs

Local office staff may fax changes to CBS. The vendor will create a task for online or mailed changes.

Related Policy

Reporting Requirements, B-620

B-474.4 Reserved for Future Use

Revision 20-2; Effective April 1, 2020

B-474.5 Replacement of Lone Star Cards or Medical Care IDs

Revision 24-4; Effective Oct. 1, 2024

SNAP

Follow regular card and PIN replacement procedures for recipients managed by CBS who request a replacement Lone Star Card or PIN.

Related Policy

Lone Star Card Replacements, B-235
PIN Replacements, B-236

Medical Programs

Replacement or temporary medical care ID cards must be issued by an HHSC local eligibility determination office using a:

- Form H1027-A, Medicaid Eligibility Verification;
- Form H1027-B, Medicaid Eligibility Verification – MQMB; or
- Form H1027-C, Medicaid Eligibility Verification – QMB.

Recipients request replacement medical care ID cards by calling 855-827-3748 or through their Your Texas Benefits account where a printable copy is also available.

B-474.6 Moving Cases Out of CBS

Revision 15-4; Effective October 1, 2015

SNAP

The CBS section:

- moves cases out of the CBS caseload if:
  - the household no longer meets the criteria to be a CBS case (earnings, loss of SSI);
  - household composition changes; or
  - because regional staff request the transfer under special circumstances;
- shortens the certification period as specified in B-474.6.1, Special Procedures for Shortening Certification Periods for Centralized Benefit Services (CBS) Eligibility Determination Groups (EDGs); and
- documents in TIERS Case Comments the reason for return.

The CBS section also returns untimely redetermination EDGs received in the month after the last benefit month to the task queue and documents in TIERS Case Comments the reason for return.

Medical Programs

Children's Medicaid – CBS moves completed Medicaid determinations, both active and denied, out of the CBS section.

B-474.6.1 Special Procedures for Shortening Certification Periods for Centralized Benefit Services (CBS) Eligibility Determination Groups (EDGs)

Revision 15-4; Effective October 1, 2015

SNAP

If the household reports a change that results in the household no longer meeting CBS caseload criteria, such as the loss of SSI benefits, an addition to the household, or moving into a GLA, then CBS staff move the EDG out of the CBS caseload.

Before moving the EDG out of the CBS caseload, CBS must take appropriate action based on the following criteria:

If the household's certification period is in ...	then ...
month 1-11,	if benefits: • will increase or decrease, send the household Form TF0001, Notice of Case Action, informing the individual that the last benefit month is month 12; and • shorten the certification period to a 12-month total by processing a change action with the new benefit amount and change the last benefit month to month 12.
month 12-36,	if benefits: • are being increased or decreased, send the household Form TF0001, Notice of Case Action, informing the household that the certification period is being shortened because it no longer meets the criteria specified in B-474, Centralized Benefit Services (CBS) Section; and • shorten the certification period to end on the last day of the month after the month Form TF0001 was sent. **Note:** CBS staff also must include Form H1830, Application/Review/Expiration/Appointment Notice, and Form H1010 — Your Texas Benefits, advising the individual how to file future applications.

B-474.7 Denied EDGs

Revision 15-4; Effective October 1, 2015

SNAP

The local office must perform an inquiry on denied EDGs to ensure the CBS section is not in the process of certifying the EDG.

Note: Advisors must accept Form H1840, SNAP Food Benefits Renewal Form, if received at the local office and the CBS SNAP EDG certification period has expired.

Medical Programs

The local office must coordinate with CBS to determine the effective date of certification when a youth certified for TP 70, TA 82, or TP 44 (Medicaid coverage to eligible youths in the custody of or released from the Texas Juvenile Justice Department), or an adult certified for TA 67, applies for Medicaid.

B-474.8 Opportunity to Register to Vote

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must mail form VR30, Texas Voter Registration Application, to households who do not have a face-to-face interview, unless form VR30 is requested through the Voter Registration Information Individual Demographic screen.

If the individual contacts the local office to decline the opportunity to register to vote after receipt of form VR30, the advisor should mail Form H1350, Opportunity to Register to Vote, to the individual for a signature. The advisor sends the completed Form H1350 for imaging and retains the form for 22 months.

Related Policy

Registering to Vote, A-1521

B-475 Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP)

Revision 13-4; Effective Oct. 1, 2013

B-475.1 Overview

Revision 25-4; Effective Oct. 1, 2025

SNAP-CAP

SNAP-CAP is a demonstration project to outreach older SSI recipients not currently certified for SNAP. Single SNAP-CAP households are certified for a standard SNAP-CAP allotment of either $115 or $161 based on their reported monthly shelter expense.

The monthly SNAP-CAP allotment is:

- $115 for households with reported monthly shelter expenses less than or equal to $624 per month; and
- $161 for households with reported monthly shelter expenses more than $624 per month.

To be eligible for SNAP-CAP, a person must:

- be an SSI recipient;
- be 50 or older;
- live in Texas;
- not live in an institution that causes ineligibility; and
- not receive regular SNAP or TSAP benefits.

Additionally, a person is not eligible to participate in SNAP-CAP if they are:

- a fleeing felon;
- disqualified due to an IPV; or
- disqualified due to a felony drug conviction that occurred on or after Sept. 1, 2015.

Other regular SNAP eligibility criteria does not apply to SNAP-CAP.

Note: An SSI recipient may choose to switch from regular SNAP to SNAP-CAP.

Related Policy

Disqualified Persons, A-232.2
Switching from the Regular SNAP Program to SNAP-Combined Application Project (CAP), B-475.2.2

B-475.2 Application Processing

Revision 23-1; Effective Jan. 1, 2023

SNAP-CAP

HHSC identifies potential SNAP-CAP recipients by the Texas State Data Exchange (SDX) match process and automatically mails Form H1841, SNAP-CAP Application, to people potentially eligible for SNAP-CAP. For people who previously received SNAP benefits in Texas, the mail-out occurs two months after the last month a person received benefits in Texas.

After Form H1841 is returned, CBS staff certify the SNAP-CAP EDG for 36 months, provide notice of eligibility, and authorize an EBT account without a face-to-face or phone interview.

If a person receives a SNAP-CAP application and also applies for SNAP at the local office, coordinate the application process with CBS staff before making an eligibility decision in the local office. This will ensure that the person can make an informed choice about their preferred program. The person may voluntarily withdraw the other application.

If the spouse of an active SNAP-CAP participant submits an application at the local office, certify the spouse separately from the active SNAP-CAP participant. If the spouse appears potentially eligible for SNAP-CAP, explain the program and requirements outlined in

Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP). The SNAP application may be withdrawn if the person wants to participate in SNAP-CAP. Refer the person to 2-1-1. Document that the person was informed of the program and the SNAP application was withdrawn.

Fax a SNAP-CAP application returned to a local eligibility determination office to the non-expedited fax line at 877-447-2839 the same day it is received.

Expedited processing and benefit proration does not apply to the SNAP-CAP program. A standard allotment is issued for the month the application is returned.

Related Policy

Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP), B-475

B-475.2.1 Identifying Intentional Program Violations (IPVs) and Felony Drug Convictions

Revision 15-4; Effective October 1, 2015

SNAP-CAP

The Data Broker vendor will receive the monthly SNAP-CAP application file and will notify state office Eligibility Operations of any clients with active out-of-state SNAP IPV disqualifications and felony drug convictions.

State office staff will forward any IPV matches to the Customer Care Center-Electronic Disqualified Recipient System (CCC-eDRS) staff using secure Voltage email at HHSC Office of Eligibility Services CCC Open Investigation (HHSC OES CCC IC) who will complete a secondary verification and then forward a completed Form H1856, SNAP Out-of-State Intentional Program Violations, to OIG at CDU@hhsc.state.tx.us, and document this action in TIERS Case Comments.

OIG Centralized Disqualification Unit (CDU) staff will enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify the advisor of the disqualification. The CBS advisor then takes appropriate action to deny the application/EDG. **Note:** If CBS staff has not yet processed the application, TIERS will ensure it is denied if the application is subsequently filed and/or processed.

State office also shares any felony drug conviction data matches with CBS. CBS staff must follow policy in A-232.2, Disqualified Persons, to take adverse action.

B-475.2.2 Switching from the Regular SNAP Program to SNAP-Combined Application Project (CAP)

Revision 15-4; Effective October 1, 2015

SNAP-CAP

If an SSI recipient receiving regular SNAP benefits wants to switch to SNAP-CAP, the individual must contact CBS staff and request to withdraw from the regular program and apply for SNAP-CAP.

Within 10 days of receipt of the request and determination that the individual meets SNAP-CAP eligibility requirements, CBS staff:

- send the individual a notice of denial for the regular SNAP, using adequate notice procedures;
- terminate the person's participation in the regular SNAP as soon as possible (that is, the end of the month the individual made the request if the 10th day falls before the monthly computer cutoff, and no later than the end of the next month); and
- send the individual a SNAP-CAP application if the individual has not already filed one with CBS.

If HHSC fails to take action within 10 days to authorize denial of the regular SNAP EDG for the applicable month, HHSC restores any lost benefits as a result of untimely agency action.

HHSC does not provide a SNAP-CAP application to anyone who does not meet the SNAP-CAP eligibility criteria. CBS also certifies eligible individuals for SNAP-CAP if the individuals submit applications they obtained on their own. CBS will coordinate termination of the individual's participation in regular SNAP, if not already terminated. To avoid duplication of SNAP benefits when an eligible individual requests to switch from the regular SNAP to SNAP-CAP, CBS staff use a file date equal to the first day of the first month the individual qualifies for SNAP-CAP, if that date is later than the date the application form is actually received. CBS staff must document in TIERS Case Comments the reason for the modified file date as compared to the date on the application form.

Note: CBS staff may also cancel a month's regular SNAP issuance in order to expedite the recipient's switch to SNAP-CAP, if it is not too late to cancel that issuance. Refer to B-331, Cancelling Benefits in EBT Accounts.

B-475.3 Household Composition

Revision 15-4; Effective October 1, 2015

SNAP-CAP

A SNAP-CAP food unit consists of one person. Married individuals who are both receiving SSI are considered separate households and certified on individual SNAP-CAP EDGs. (See A-231, Who Is Included.)

A SNAP-CAP participant who resides in a household in which other members receive SNAP through the regular program is considered a separate household, regardless of how they purchase and prepare their meals. (See A-232.1, Nonmembers.)

Do not include a SNAP-CAP participant when determining regular SNAP eligibility for other household members. Follow policy in .

A minor child residing with a SNAP-CAP participant may be certified as SNAP head of household. The SNAP-CAP participant must be listed as the AR on the minor child's EDG. (See A-231.)

B-475.4 Income

Revision 13-4; Effective October 1, 2013

SNAP-CAP

SSI eligibility is verified weekly via the SNAP-CAP participant's SDX record.

B-475.5 Shelter and Utility Expenses

Revision 15-4; Effective October 1, 2015

SNAP-CAP

Advisors follow policy in A-1429, Shelter Costs, for separate households sharing shelter expenses, including standard utility allowance (SUA)/basic utility allowance (BUA), if applicable.

B-475.6 Changes

Revision 15-4; Effective October 1, 2015

SNAP-CAP

SNAP-CAP participants are not required to report changes. CBS processes shelter and address changes reported by SNAP-CAP participants.

CBS will mail form VR30, Texas Voter Registration Application, to the individual when the individual reports a change of address. If the individual contacts CBS to decline the opportunity to register to vote after receipt of form VR30, CBS will mail Form H1350, Opportunity to Register to Vote, to the individual for a signature. After the household returns Form H1350, the advisor sends the form for imaging and retains the image for 22 months.

State office uses SDX records to automatically update individual information on a weekly basis. The weekly SDX update results in a SNAP-CAP EDG denial if the individual no longer receives SSI, dies or moves to a nursing home.

Related Policy

Registering to Vote, A-1521

B-475.7 Issuing Benefits

Revision 24-4; Effective Oct. 1, 2024

SNAP-CAP

CBS staff authorize benefits and request Lone Star Card issuance for SNAP-CAP recipients. Lone Star Cards may also be obtained from an HHSC local eligibility determination office.

Related Policy

Issuing a Lone Star Card, B-233
Lone Star Card Replacements, B-235

B-475.8 Fair Hearings

Revision 13-4; Effective October 1, 2013

SNAP-CAP

Follow policy in B-1000, Fair Hearings.

B-475.9 Claims

Revision 19-4; Effective October 1, 2019

SNAP-CAP

Staff file an overpayment referral when a household receives benefits it is not entitled to receive. This may occur based on agency error, applicant or recipient error or misunderstanding, through fraud or an Intentional Program Violation (IPV). OIG receives the overpayment referral and establishes a claim if the referral is valid.

SNAP-CAP households are subject to overpayment referrals and claims. Households may repay benefits through either recoupment or restitution. Recoupment is a method of recovering an overpayment claim by withholding a portion of the household's benefits. Restitution is a method of recovering an overpayment claim by the receipt of payments from the household paid to HHSC.

Related Policy

Claims, B-700
Filing an Overpayment Referral, B-770

B-475.10 Redeterminations

Revision 15-4; Effective October 1, 2015

SNAP-CAP

State office automatically mails Form H1842, SNAP-CAP Renewal Application, two months before the last benefit month. To reapply in a timely manner, the individual must submit the completed Form H1842 by the 15th day of the last benefit month.

CBS staff must process timely redeterminations by the last workday of the certification period. CBS staff certify the SNAP-CAP EDG for 36 months and provide a notice of eligibility without a face-to-face or telephone interview. Advisors must ensure that the individual's normal issuance cycle is not interrupted.

If CBS receives Form H1842 after the 15th day of the last benefit month, advisors certify or deny the application by the 30th day after the file date. Expedited processing and benefit proration do not apply to SNAP-CAP.

A Form H1842 returned to a local eligibility determination office must be faxed to CBS the same day it is received. The fax number is 1-877-447-2839.

B-475.10.1 Opting Out of SNAP-CAP

Revision 15-4; Effective October 1, 2015

SNAP-CAP

Individuals currently receiving SNAP-CAP may choose to apply for traditional SNAP because they may be eligible for a higher allotment. If an individual returns Form H1010, Texas Works Application for Assistance — Your Texas Benefits, and chooses to opt out of SNAP-CAP, the local office must:

- contact and confirm the applicant wants to apply for benefits under regular SNAP;
- schedule an appointment for an interview;
- perform Application Registration using a different SNAP EDG number than the SNAP-CAP EDG number;

- determine if the individual would receive a higher allotment under regular SNAP;
- notify the individual of the allotment amount under regular SNAP and confirm if the individual wishes to withdraw from SNAP-CAP;
- contact 2-1-1 to request EDG closure because the individual wishes to withdraw from SNAP-CAP;
- confirm the SNAP-CAP EDG has been denied; and
- certify the individual for regular SNAP effective the first month the individual qualifies for benefits without duplicating benefits.

B-476 Joint Supplemental Security Income (SSI)-SNAP Applications

Revision 15-4; Effective October 1, 2015

B-476.1 Applications Filed in the Social Security Office

Revision 15-4; Effective October 1, 2015

SNAP

Households whose members are all applying for or receiving SSI may apply for SNAP at the SSA office unless the households already have a SNAP application pending. These individuals are not required to come to the SNAP office to complete the application or redetermination process. If more information is needed from the household, the advisor must contact the household by home visit, telephone, or mail.

SSA:

- accepts and completes the SNAP application during the SSI interview; and
- forwards the following items to the Document Processing Center within one workday after receiving the application:
  - the application;
  - Form SSA-4233, Social Security Administration Transmittal for Food Stamp Applications; and
  - any verification SSA has received.

The file date for the application is the date SSA receives the application. SSA notes this date on Form SSA-4233. When SSA receives additional verification after forwarding the application to the Document Processing Center, SSA sends the additional verification with Form SSA-4233.

B-476.1.1 Expedited Service

Revision 15-4; Effective October 1, 2015

SNAP

Advisors determine expedited services eligibility for SSI households the same as other households, except expedited time limits begin with the date the correct SNAP office receives the application.

SSA staff:

- screen the application for expedited services on the day they receive it;
- note "Expedited Processing" on the first page of , Texas Works Application for Assistance — Your Texas Benefits, if the household appears to be eligible; and
- fax the application within one workday to the Document Processing Center's expedited fax number.

The individual may also take the application to the SNAP office.

B-476.1.2 Work Registration

Revision 22-1; Effective January 1, 2022

SNAP

SSI household members who apply for SSI and SNAP at the Social Security office are exempt from work registration until the SSA determines their eligibility for SSI.

Related Policy

SNAP Work Requirement Exemptions, A-1822.1

B-476.1.3 Special Review

Revision 15-4; Effective October 1, 2015

SNAP

For households applying at SSA, advisors process a special review during the third month of the certification period to determine whether the individual received a decision on the SSI claim.

B-476.1.4 Notice of Expiration

Revision 13-4; Effective October 1, 2013

SNAP

TIERS sends Form H1830-R, Texas Works Renewal Notice, to the SSI household:

- no earlier than the month before the last month of the certification period, and
- no later than the first day of the last month of the certification period.

The notice of expiration informs the individual:

- what programs are due for redetermination,
- verifications needed for the redetermination,
- when the redetermination application and verifications are due, and
- the individual's rights and responsibilities.

B-476.1.5 Reporting Changes

Revision 15-4; Effective October 1, 2015

SNAP

These households are subject to the same change reporting requirements as other SNAP households.

HHSC receives information on whether the SSI was granted or denied through an interface with SSA. Advisors must take action on information from this or any other source.

Related Policy

Reporting Requirements, B-620

B-476.1.6 Redetermination

Revision 13-4; Effective October 1, 2013

SNAP

Households in which all members are applying for or receiving SSI may file a redetermination for SNAP at the SSA.

The SSA office sends:

- the application,
- transmittal sheet (Form SSA-4233), and
- any available verification to the Document Processing Center.

B-476.2 Applications Filed in Public Institutions

Revision 22-3; Effective July 1, 2022

SNAP

A resident of a public institution may jointly apply for SSI and SNAP while in the institution if scheduled for release within 30 days.

SSA staff:

- within one business day, send non-expedited applications to:
  - HHSC
    P.O. Box 149024
    Austin, TX 78714-9024; or
  - fax to 877-447-2839;
- within one business day, fax expedited applications to 866-559-9628;
- note "PRERELEASE" in red ink across the top of Form H1010, Texas Works Application for Assistance — Your Texas Benefits;
- send Form SSA-4233 to HHSC; and
- give HHSC the name, address and phone number of a staff contact at the institution.

When the person does not have a post-release address, SSA holds the application for 30 days and documents its actions. SSA sends these applications and Form SSA-4233 to HHSC within one business day when:

- SSA receives a post-release residence address;
- release has occurred, but SSA has not received a post-release address;
- SSA denies SSI prior to release; or
- release from the institution is canceled.

HHSC staff:

- register the application; and
- pend the application until SSA notifies HHSC that the applicant has been released.

If the applicant is:

- not released, HHSC denies the application.
- released, HHSC determines eligibility for benefits, including expedited services. HHSC offers benefits to allow the person a chance to participate per the application processing time frames.

Note: The file date is the date the applicant is released from the institution. The file date is day zero.

Certification Period or Special Review — Process a special review during the third month of the certification period to determine whether the person receives SSI.

Related Policy

Application Processing, A-100

B-477 Texas Simplified Application Project (TSAP)

Revision 22-3; Effective July 1, 2022

B-477.1 Overview

Revision 22-3; Effective July 1, 2022

TSAP

For the TSAP caseload, Texas is operating under a waiver. The waiver allows the state to provide a simplified application and certification process for certain persons applying for SNAP. TSAP provides a 36-month certification period and does not require an interview at recertification.

B-477.2 Application Processing

Revision 22-3; Effective July 1, 2022

TSAP

Eligibility

TSAP follows all regular SNAP policy and processes with the following differences:

To be eligible for TSAP, households must meet the following criteria:

- All household members are 60 or older, receive disability payments, or both;
- have no earned income; and

- No household member receives SNAP benefits under the SNAP-Combined Application Project (SNAP-CAP).

Applications

People can apply for TSAP using Form H0011, Texas Simplified Application Project (TSAP) for SNAP Food Benefits, Form H1010, Texas Works Application for Assistance – Your Texas Benefits, or online at YourTexasBenefits.com.

At recertification, TSAP households are provided Form H1011-R, Texas Simplified Application Project (TSAP) for Food Benefits Renewal. They can also reapply using Form H1010, Form H1010-R, Your Texas Works Benefits: Renewal Form, or online at YourTexasBenefits.com.

Applicants cannot select TSAP on Form H1010. However, new SNAP applicants and active SNAP households are tested for TSAP eligibility as part of the SNAP application and recertification process, regardless of the type of SNAP application submitted, and are certified for TSAP if eligible. Additionally, applicants who use the Form H0011 or H0011-R to apply for TSAP will be automatically tested for SNAP eligibility if not eligible for TSAP.

Additionally, automated monthly screenings occur to identify Medicaid households that are potentially eligible for TSAP but are not currently receiving SNAP benefits. These Medicaid households will receive a TSAP application packet and an accompanying cover letter, Form H0011A, TSAP Outreach Cover Letter, detailing TSAP requirements and their potential eligibility.

Interviews

An interview is required at initial certification for TSAP, but waived at recertifications with the following exceptions:

- prior to denying a TSAP recertification;
- if information supplied by the household or authorized representative is questionable, incomplete or contradictory; or
- if the TSAP household requests an interview.

Verification

Accept the applicant's statement and use data matching to verify as much information as possible. Only request more information from the household to resolve questionable information. Out-of-pocket medical expenses still require verification if the person wants to claim a medical deduction.

Related Policy

Budgeting Medical Deductions, Households with Elderly Members or Members with a Disability, A-1428.2
B-430
Questionable Information, C-920

B-477.3 SNAP Conversion

Revision 22-3; Effective July 1, 2022

TSAP

A TSAP household will convert to regular SNAP and maintain their assigned TSAP certification period if the TSAP household becomes ineligible for TSAP during their certification period (but remains eligible for SNAP) due to:

- the loss of disability payments;
- an addition of a non-elderly or non-disabled member; or
- the receipt of earned income.

B-477.4 Change Reporting

Revision 22-3; Effective July 1, 2022

TSAP

All TSAP households meet the streamlined reporting criteria and must report changes in accordance with the reporting requirements for this group. TSAP households will receive Form H0586, TSAP Change Reminder, once every 12 months during the 36-month certification period, reminding the household of what changes to report, how to report changes and the consequences of not reporting required information. TSAP households are not required to return Form H0586.

Related Policy

Streamlined Reporting Households, A-2350
Reporting Requirements, B-620

B-480, A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20

Body

Revision 15-4; Effective October 1, 2015

TANF

When household members on a TANF EDG that includes other-related children become ineligible, and the other-related children remain eligible for TANF, advisors must ensure the other-related children continue to receive TANF.

Advisors must:

- deny the TANF or TANF-SP EDG; and
- continue the TANF for the other-related children.

TP 08

If a caretaker relative who receives TP 08 based on caring for (an) other-related child(ren) receiving Medicaid becomes ineligible for TP 08 due to new or increased earnings or spousal support and begins receiving TP 07 or TP 20, the other-related child(ren) will also transition from their TP 43, TP 44, or TP 48 EDG to a TP 07 or TP 20 EDG.

B-481 EDGs That Include an Other-Related Child

Revision 15-4; Effective October 1, 2015

B-481.1 At Initial Certification

Revision 15-4; Effective October 1, 2015

TANF or TANF-SP

When a TANF EDG includes an other-related child, advisors must:

- explain to the household that the other-related child, if eligible alone, can continue receiving TANF even if the TANF for the other members of the household is denied. Denials include, but are not limited to, those because of:
  - resources,
  - earnings, or
  - child support.
- advise households that have an other-related child included in the TANF EDG to contact HHSC immediately if they receive a notice in the mail stating that their TANF or TANF-SP will be denied because they are no longer eligible for the 90 percent earned income deduction.
- set a special review to contact the household and continue TANF for an eligible other-related child when the EDG is expected to be denied because the 90 percent earned income deduction will be removed.

B-481.2 Before a TANF or TANF-SP EDG Is Denied

Revision 15-4; Effective October 1, 2015

TANF

Advisors determine whether an other-related child is eligible for TANF on a separate EDG before the household's TANF is denied. Advisors must contact the household to ensure that the household wants the child's TANF to continue.

Advisors provide TANF to the other-related child without a break in benefits, if the other-related child is eligible alone and the household:

- wants the other-related child's TANF to continue, or
- cannot be contacted.

If more than one other-related child is in the household, other-related children who are not siblings are certified on separate EDGs. **Exception:** The individual may choose to combine EDGs if one EDG is ineligible separately but would be eligible if the members were combined.

The other-related child is kept in the original household group if the:

- child is not eligible alone, or
- the household does not want the child to receive TANF.

B-482 Separating Household Members

Revision 15-4; Effective October 1, 2015

TANF

The eligibility system creates an EDG for the other-related child's TANF. Advisors must verify that each certified group contains the correct members. Advisors also must ensure that a new Lone Star Card is issued for the other-related child's new EDG. A new application is not required.

Note: These procedures ensure that TANF-SP EDG numbers follow the SP members.

B-490, Determining Whether a Person Who Resides in a Facility Is Institutionalized

Body

Revision 22-1; Effective January 1, 2022

SNAP

People residing in institutions that are not approved are potentially eligible for SNAP, only if the person is not considered institutionalized. Approved institutions include homeless shelters, Drug and Alcohol Treatment (D&A), Group Living Arrangement (GLA) Facilities, and family violence shelters.

Additionally, people who reside together and receive residential services from nonprofit organizations or for-profit providers who contract with HHSC to provide residential services may participate in SNAP, only if the person is not considered institutionalized.

Residential services providers may:

- manage a resident's personal funds at the request of the resident; or
- be the payee on the resident's SSI benefit check.

If the person requests the residential services provider to manage the resident's personal account, the provider must maintain a financial account for the person and a separate detailed record of all deposits and expenditures for each resident.

Residential services providers may not commingle the resident's personal funds with the provider's funds.

For people residing in a facility or receiving residential services, staff must determine whether a person is institutionalized for SNAP eligibility following the steps below:

Step	Yes	No
1. Does the person do their own shopping and preparation for more than 50 percent of their meals, **or** do the facility staff manage the resident's personal account (which can include SNAP benefits) and use those funds to purchase a majority of the person's meals and prepare them for the resident?	The resident is **not** considered institutionalized. The person is eligible for SNAP if all other SNAP eligibility requirements are met. Go to Step 3.	Go to Step 2.
2. Does the facility: • contract with HHSC to furnish a majority of the resident's meals along with other services;	The resident is considered "institutionalized" for purposes of SNAP eligibility since the contractor is providing most meals for the person. The resident can only qualify if the person meets the	The resident is **not** considered institutionalized. The person is eligible for SNAP if all other SNAP eligibility requirements are met. Go to Step 3.

Step	Yes	No
• provide a majority of the resident's meals from food purchased with money other than the person's funds; or • charge the resident a standard fee for a majority of the person's meals?	requirements for a resident of a nonprofit GLA.	
3. Does the resident purchase **and** prepare their meals separately from others (including situations in which an attendant purchases food for the person with the person's money and prepares the person's meals separately from other people's), **or** does the resident intend to purchase and prepare separately after certification for SNAP?	The person can apply as a one-person household following regular policy.	People who purchase **or** prepare their food together must be included on the SNAP application. HHSC determines eligibility for all those purchasing or preparing together. **Example:** The facility uses every resident's specific SNAP funds to purchase groceries and prepare meals for everyone together. In this example, all the residents must be certified together for SNAP.

Verify and document the answers to the questions in the chart. If the person designates provider staff as the AR and the AR states the attendant purchases meals or food using the person's funds, the AR must provide a detailed record of deposits and expenditures for these people.

Related Policy

Applications from Residents of a Homeless Shelter, A-116.2
General Policy, A-210
Drug and Alcohol (D&A) or Group Living Arrangement (GLA) Facilities, B-440
Residents of GLA Facilities, B-442
Residents in Family Violence Shelters, B-450

B-491 Documentation Requirements

Revision 22-1; Effective January 1, 2022

SNAP

For households receiving residential assistance, document responses to the questions when determining if a person who resides in a facility is institutionalized.

Related Policy

Determining Whether a Person Who Resides in a Facility Is Institutionalized, B-490

B-500, Medical Coverage for People Confined in a Public Institution

B-510, Termination of Medical Coverage for People Confined in a Public Institution

Body

Revision 20-4; Effective October 1, 2020

All Medical Programs

Medical coverage is terminated for people confined in a public institution, except as provided in Section B-520, Medicaid Suspension, and Section B-541, Inpatient Services Provided to Inmates of the Texas Department of Criminal Justice (TDCJ). When a report of confinement is received, follow policy in B-631, Actions on Changes, to terminate the person's eligibility.

Related Policy

Medicaid Suspension, B-520
Inpatient Services Provided to Inmates of the Texas Department of Criminal Justice (TDCJ), B-541
Actions on Changes, B-631

Child Leaves the Home, D-1433.2
General Policy, W-910
Medicaid Termination, X-923

B-520, Medicaid Suspension

Body

Revision 24-2; Effective April 1, 2024

Suspend Medicaid in the following circumstances:

People Certified for TA 82, TP 40, TP 44 and TP 70 Confined in a Texas County Jail

Suspend Medicaid if the person is confined in a Texas county jail for more than 30 days and the county jail chooses to report the person's confinement to HHSC. The person's Medicaid suspension is effective the day after the confinement is reported by the county jail.

If notified of the person's confinement from a source other than a Texas county jail, terminate the person's Medicaid.

If notified of a child's confinement from a source other than a Texas county jail, sustain the child's Medicaid.

Children Certified for TP 44 Confined in a Secured Juvenile Facility

Suspend Medicaid when a child is placed in a secured juvenile facility. The Texas Juvenile Justice Department (TJJD) or a Juvenile Probation Department (JPD) makes the report to HHSC within 30 calendar days of a child's placement. The child's TP 44 suspension is effective the day after TJJD or a JPD notifies HHSC that the child is placed in a juvenile facility.

If notified of the person's confinement from a source other than a Texas county jail, terminate the person's Medicaid.

The following are scenarios for a child certified on Medicaid who is reported as placed in a juvenile facility.

Child is certified for…	and HHSC receives notification of the child's placement in a juvenile facility from...	then the child's…
TP 44 from Dec. 1, 2014 – Nov. 30, 2025	TJJD on Feb. 7, 2024,	TP 44 eligibility is suspended effective Feb. 8, 2024.
TP44 from Oct. 1, 2024 – Sept. 30, 2025	the child's mother on Dec. 1, 2024.	TP44 is sustained.

Related Policy

Termination of Medical Coverage for People Confined in a Public Institution, B-510
Persons Confined in a Texas County Jail, B-542
Child Placed in a Secured Juvenile Facility, B-543
General Policy, E-1010
Three Months Prior Coverage, M-1010

B-530, Medicaid Reinstatement

Body

Revision 20-4; Effective October 1, 2020

B-531 Medicaid Reinstatement for Children Certified for TP 44 Who Are Released from a Juvenile Facility

Revision 20-4; Effective October 1, 2020

TP 44

Upon receiving notification from the Texas Juvenile Justice Department (TJJD) or a Juvenile Probation Department (JPD) that a child whose Medicaid is suspended has been released and the child has months remaining on their original certification period:

- reinstate the child's eligibility effective the date of their release, and
- certify the child for any remaining months of the child's original certification period.

Add the child back to any associated active TANF, SNAP, Medicaid, CHIP, or Medicaid for the Elderly and People with Disabilities (MEPD) EDGs if the child is a required member of the household.

The child's eligibility is reinstated even if the child is released to a household that is different than the one in which the child resided at the time of their placement.

If the child is not eligible for reinstatement but is released to a home in which a sibling is receiving Medicaid or CHIP, add the child to the sibling's case.

If the child is released to the same household and the case is…	Then…
Active or denied	The child's TP 44 eligibility is reinstated for the remainder of the child's original certification period on the same EDG.

If the child is released to a different household…	Then…
With an existing denied case	The child's TP 44 eligibility is reinstated for the remainder of the original certification period on a new EDG.
Without an existing case	The child's TP 44 eligibility is reinstated for the remainder of the child's original certification period on a new case.

For a child released to a different household, any changes to the child's circumstances should be addressed at the next scheduled renewal. A child released to a different household may not administratively renew.

If the child is released as an independent child with…	Then…
An existing denied case	The child's TP 44 eligibility is reinstated for the remainder of the child's original certification period on a new EDG.
Without an existing case	The child's TP 44 eligibility is reinstated for the remainder of the child's original certification period on a new case.

For a child released as an independent child, any changes to the child's circumstances should be addressed at the next scheduled renewal. A child released to a different household may not administratively renew.

TIERS will automatically reinstate the child's eligibility for the remainder of the certification period and add the child to any associated active EDGs upon notification from TJJD or a JPD. When an exception to the automated process occurs, CBS staff must manually process the reinstatement or add the child to an existing case following B-545, Notification of Actual Release.

Related Policy

Medicaid Suspension, B-520
Child Placed in a Secured Juvenile Facility, B-543
Child Placed in a Non-Secure Facility, B-544
Notification of Actual Release, B-545

B-532 Medicaid Reinstatement for Persons Released from Texas County Jails

Revision 20-4; Effective October 1, 2020

TA 82, TP 40, TP 44 and TP 70

When notified by any source that a person has been released from a Texas county jail, perform individual inquiry to determine if the person:

- has suspended or terminated health care coverage due to county jail confinement; and
- was included in the budget or certified group of any other EDGs at the time their health care coverage was suspended or terminated.

If inquiry shows that the person's health care coverage was suspended at confinement, perform a **County Jail Release - Search** to determine if the person has an active suspension (months remaining on their original certification). If so, create a *Process a County Jail Confinement/Release* task for all active cases on which the person was included prior to suspension and enter the release information into TIERS on the **County Jail Release - Details** page.

When the health care coverage EDG is disposed:

- The person's health care coverage is reinstated for the remaining months of the original certification period, effective the date the person is released from the county jail.
- The **Individual - Medicaid History** page is updated to indicate the person's eligibility has been reinstated.
- A TF0001, Notice of Case Action, is generated notifying the person of reinstatement.

Reinstatement must occur within two business days of receiving the notification of the person's release.

Consider the report of release as a change report for all other types of assistance and follow policy in B-641, Additions to the Household, to determine if the person needs to be added to the other types of assistance.

If inquiry shows that the person's health care coverage was terminated at confinement or that the person's original certification has ended and is not eligible for reinstatement, send an application to the person's last known address.

Related Policy

Termination of Medical Coverage for People Confined in a Public Institution, B-510
Medicaid Suspension, B-520
Additions to the Household, B-641
General Policy, E-1010
Action on Changes, E-2220
General Policy, M-1010
Action on Changes, M-2220

B-533 Reasonable Opportunity After a Medicaid Suspension and Reinstatement

Revision 20-4; Effective October 1, 2020

TA 82, TP 40, TP 44 and TP 70

If a person's reasonable opportunity period expires while their Medicaid is suspended, a new reasonable opportunity period is provided when their Medicaid coverage is reinstated. The new reasonable opportunity period is the earlier of the following:

- 95 days from the date the reinstatement is disposed; or
- the last day of their current certification period.

If the person's Medicaid coverage is reinstated before the original reasonable opportunity period end date, their original reasonable opportunity due date is retained.

A TF0001, Notice of Case Action, is generated at reinstatement and will include the reasonable opportunity information to remind the person to submit documentation of citizenship or alien status.

Related Policy

Reasonable Opportunity, A-351.1

B-540, Centralized Benefit Services

Body

Revision 20-4; Effective October 1, 2020

B-541 Inpatient Services Provided to Inmates of the Texas Department of Criminal Justice (TDCJ)

Revision 20-4; Effective October 1, 2020

TP 44 and TP 40

This section applies only to people confined in a Texas Department of Criminal Justice (TDCJ) facility. This policy does not apply to any other state, county, or city jails. Applications are submitted to HHSC only by The University of Texas Medicaid Branch at Galveston.

A person confined in a public institution is eligible for Medicaid coverage if the following conditions are met:

- the confined person meets Medicaid eligibility requirements (pregnant women and children through age 18 could meet current Medicaid eligibility requirements);
- the confined person receives inpatient services; and
- the inpatient services are provided by a hospital that is not on the premises of a prison, jail, detention center, or other penal setting, including a facility run by a private health care entity.

Medicaid coverage is limited to the specific days the confined person is admitted as a patient and receives inpatient services as verified by the medical provider using Form H1046, Inpatient Medical Services Certification. Inpatient services are those provided on the recommendation of a physician or dentist and received in a medical institution. The confined person must receive or expect to receive room, board, and professional services in the institution for a 24-hour period or longer.

If the confined person is ineligible due to U.S. citizenship or alien status, the medical provider must also complete Form H3038, Emergency Medical Services Certification. The ineligible person is eligible only for those dates verified as an emergency, even if the inpatient treatment continues after the verified emergency dates.

The confined person is eligible for prior coverage only.

The TDCJ or its designee submits the following documents to HHSC via fax:

- Form H1205, Texas Streamlined Application, on behalf of the confined person the month following the month the eligible hospital bill was incurred;
- Form H1046, Inpatient Medical Services Certification;
- Form H3038, Emergency Medical Services Certification, if applicable; and
- all required verification, such as verification of citizenship, alien status, etc.

Note: If the required information or verification is not received, call or send secure email to the designated TDCJ contact.

Upon disposition of the application, send Form TF0001, Notice of Case Action, to the representative's address provided on Form H1205, Texas Streamlined Application.

Related Policy

Applications for Babies Born to Women in Prison, A-116.3

B-542 Persons Confined in a Texas County Jail

Revision 20-4; Effective October 1, 2020

All Medical Programs

A county jail may choose to report people who receive health care coverage from HHSC and are confined in their facility for more than 30 days. If applicable, within two business days of the confinement report, Centralized Benefit Services (CBS) staff must review the report of confinement and determine the appropriate action needed.

CBS staff:

- Suspend the following types of health care coverage:
  - TA 82, MA – Former Foster Care Children
  - TP 40, MA – Pregnant Women
  - TP 44, MA – Children 6–18
  - TP 70 - Medicaid for the Transitioning Foster Care Youth (MTFCY)
- Terminate the following types of health care coverage:
  - TA 41, Health Care – Healthy Texas Women (HTW)
  - TA 66, MA – MBCC – Presumptive
  - TA 67, MA – MBCC
  - TA 76, MA – Children 6–18 Presumptive
  - TA 77, Health Care – FFCHE
  - TA 83, MA – FFCC Presumptive
  - TA 84, CI – CHIP
  - TA 85, CI – CHIP perinatal
  - TA 86, MA – Parents and Caretaker Relatives Presumptive
  - TP 07, MA – Earnings Transitional
  - TP 08, MA – Parents and Caretaker Relatives
  - TP 20, MA – Alimony/Spousal Support Transitional
  - TP 42, MA – Pregnant Women Presumptive

Do not act on other types of health care coverage.

When the Eligibility Determination Group (EDG) is disposed, if applicable:

- The person's health care coverage is suspended or terminated effective the day after HHSC receives the notification. The person receives Medicaid through the date of the confinement notification.
- The **Individual – Medicaid History** page is updated to indicate the person's eligibility is suspended or terminated.

- The person is removed from other EDGs in which they are included, and benefits are adjusted accordingly for the remaining household members following current policies and procedures.
- A TF0001, Notice of Case Action, is generated at suspension/termination and reinstatement (TWH Section A-2310, Notice to Applicants).

Note: Terminate the person's eligibility following policy in B-631, Actions on Changes, if a report of confinement in a county jail is received from a source other than a participating county jail.

Related Policy

Termination of Medical Coverage for People Confined in a Public Institution, B-510
Medicaid Suspension, B-520
Actions on Changes, B-631
General Policy, E-1010
General Policy, M-1010

B-543 Child Placed in a Juvenile Facility

Revision 24-2; Effective April 1, 2024

TP 44

The TJJD or a JPD notify HHSC within 30 days of a child's placement in a juvenile facility. When notified of the placement:

- suspend the child's Medicaid eligibility effective the day after HHSC receives the notification if the child is certified for TP 44;
- sustain the child's Children's Health Insurance Program (CHIP) eligibility;
- sustain the child's Medicaid eligibility, if the child is certified on a Medicaid type other than TP 44; and
- remove the child from other Eligibility Determination Groups (EDGs) in which the child is included.

The child receives TP 44 eligibility through the date of the notification of placement.

The following are scenarios for a child certified on Medicaid who is reported as placed in a juvenile facility.

Child is certified for	and HHSC receives notification of the child's placement in a juvenile facility from	then the child's
TP 44 from Dec. 1, 2024 – Nov. 30, 2025	TJJD on Feb. 7, 2025,	TP 44 eligibility is suspended effective Feb. 8, 2025.
TP 44 from Oct. 1, 2024 – Sept. 30, 2025	the child's mother on Dec. 1, 2024,	TP 44 eligibility is sustained.

Exceptions:

- Children certified on a Supplemental Security Income (SSI) or a Department of Family and Protective Services (DFPS) type of Medicaid are not terminated by HHSC.
- Children placed in a non-secure facility may receive TP 44 as an independent child. Therefore, these EDGs are not suspended or denied when a notification of placement is received.

TIERS will automatically suspend or sustain the child's eligibility and remove the child from associated active EDGs upon notification from TJJD or a JPD. When an exception to the automated process occurs, CBS must manually suspend, sustain, or remove the child from associated EDGs.

Related Policy

Termination of Medical Coverage for People Confined in a Public Institution, B-510
Medicaid Suspension, B-520
Medicaid Reinstatement for Children Certified for TP 44 Released from a Juvenile Facility, B-531
Child Placed in a Non-Secure Facility, B-544

B-544 Child Placed in a Non-Secure Facility

Revision 24-1; Effective Jan. 1, 2024

TP 44

When reporting that a child has been placed in a juvenile facility, Texas Juvenile Justice Department (TJJD) or a Juvenile Probation Department (JPD) notifies HHSC if the facility is a secure or non-secure facility.

Non-secure TJJD or JPD halfway house facilities with more than 16 beds and non-secure juvenile facilities with 16 or fewer beds may apply for medical assistance on behalf of the children under their care. Independent children residing in a TJJD or a JPD halfway house with more than 16 beds may be eligible for Medicaid if the child meets all other eligibility criteria and the half-way house meets the federally required children's living arrangement criteria.

These facilities have limited power of attorney and are considered alternate payees for the children's Medicaid EDG. A facility submits an application listing the child as a case name and a representative from the facility as an authorized representative (AR). If the representative is no longer affiliated with the facility, the facility must name a new representative to serve as the child's AR. When a child moves out of the facility, it is the responsibility of the facility's AR to report the change of address and to end the AR designation.

Medical Effective Date

To determine the correct medical effective date (MED) for children in a non-secure facility, follow the chart below:

If the child is	then
not active on Medicaid or Children's Health Insurance Program (CHIP) and the file date is within the same month as the placement date of the child,	the MED is the date the child was placed in the non-secure facility.
not active on Medicaid or CHIP and the file date is not within the same month as the placement date of the child (the application is filed the month after the placement date),	the MED is the first day of the application month. **Note:** For unpaid medical bills before the file date, follow policy in How to Apply for Three Months Prior Coverage.
active on CHIP,	test for Medicaid eligibility following procedures in Advisor Action for Determining Eligibility for Children.
receiving SSI or Foster Care Title IV-E any time during application month or within same month child is placed,	deny the application.

Related Policy

Advisor Action for Determining Eligibility for Children, A-126.3
Children's Living Arrangement, A-241.3.1
How to Apply for Three Months Prior Coverage, A-831.1
Reporting Requirements, B-620

B-545 Notification of Anticipated Release from Juvenile Facility

Revision 20-4; Effective October 1, 2020

TP 44

At least 30 days prior to a child's release, TJJD or a JPD notifies HHSC of the child's anticipated release date. Upon receipt of the information, CBS staff determines whether the child:

- is eligible for reinstatement of TP 44 eligibility;
- can be added to an existing case if not eligible for reinstatement; or
- must reapply.

If the child cannot be reinstated because their original certification period has ended or their TP 44 was not suspended or cannot be added to an existing case, CBS staff are notified in the HHSC Action Status field on the **TIERS TJJD/JPD Release** page, to send the household an application packet. The application packet includes the following:

- Form H1205, Texas Streamlined Application;
- a pre-paid envelope addressed to CBS;
- a cover letter that provides information and instructions for submitting the application and obtaining help in completing the application; and
- a list of Community Partners in the household's area that provide application assistance upon request.

Related Policy

Notification of Actual Release from a Juvenile Facility, B-546

B-546 Notification of Actual Release from a Juvenile Facility

Revision 24-2; Effective April 1, 2024

TP 44

After TJJD or a JPD provide notification of the child's actual release, reinstate eligibility for a child who has suspended eligibility, if there are months remaining on the child's original certification period.

Medicaid coverage will be reinstated if there are any months left in the child's 12-month certification period. The child will receive continuous eligibility (CE) for the remaining months.

The child is automatically added to an existing case if they are not eligible for reinstatement but have a sibling receiving Medicaid or CHIP. The child is also added to any other EDGs on the case that require the child to be a household member.

TIERS will automatically reinstate the child's eligibility and add the child to associated active EDGs upon notification from TJJD or a JPD. When an exception to the automated process occurs, CBS must manually process the reinstatement or add the child to an existing case.

CBS staff must process and dispose any pending applications in two business days of notification of the child's release.

CBS accepts applications up to and including the 14th calendar day after the confirmed release date. Any applications received after the 14th calendar day are routed to the local office for processing.

CBS reports the following to TJJD through the Juvenile Medicaid Tracker:

- the child has Medicaid or CHIP;
- the child was denied;
- the CBS unit never received the application; or
- the application was sent to the local office.

If the child is eligible for Medicaid, the MED cannot be any earlier than the release date.

Related Policy

Regular Medicaid Coverage, A-820
Adverse Actions Not Requiring Advance Notice, A-2344
Medicaid Suspension, B-520
Medicaid Reinstatement for Children Certified for TP 44 Who Are Released from a Juvenile Facility, B-531
Additions to Household, B-641

B-547 Inpatient Services Provided to Juvenile Inmates

Revision 22-3; Effective July 1, 2022

TP 40 and TP 44

This section only applies to people confined in Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) facilities. This policy does not apply to any other state, county or city jails. Applications are only submitted to HHSC by TJJD.

A person confined in a juvenile public institution is eligible for Medicaid coverage if:

- the confined person meets all other Medicaid eligibility requirements (pregnant women and children through 18 could meet current Medicaid eligibility requirements);
- the confined person receives inpatient services; and
- the inpatient services are provided by a hospital, including a facility run by a private health care entity, that is not on the premises of a prison, jail, detention center or other penal setting.

Medicaid coverage is only available for the specific days the confined person is admitted as a patient and receives inpatient services as verified by the medical provider using Form H1046, Inpatient Medical Services Certification. Inpatient services are those services provided on the recommendation of a physician or dentist and received in a medical institution. The confined person must receive or expect to receive room, board and professional services in the institution for a 24-hour period or longer.

If the confined person is ineligible due to U.S. citizenship or immigration status, the medical provider must also complete Form H3038, Emergency Medical Services Certification. The person is eligible only for dates verified as an emergency, even if the inpatient treatment continues after the verified emergency dates identified on Form H3038.

The confined person is only eligible for prior Medicaid coverage.

TJJD submits the following documents to HHSC via YourTexasBenefits.com:

- YourTexasBenefits.com online application on behalf of the confined person the month following the month the person incurred the eligible hospital bill;
- Form H1046;
- Form H3038, if applicable; and
- all required verification for the applicable Medical assistance program, such as verification of citizenship, immigration status, etc.

Note: If TJJD does not provide the required information or verification with the application, call or send a secure email to the designated TJJD contact to request the necessary information.

If the child has an existing case as part of a household with other members in TIERS, perform Application Registration to certify the prior Medicaid coverage on a separate case number from the existing household's case. Upon disposition of the application, send Form TF0001, Notice of Case Action, to the representative's address provided on the application.

Related Policy

Medicaid Suspension, B-520
Medicaid Reinstatement for Children Certified for TP 44 Who Are Released from a Juvenile Facility, B-531

B-600, Changes

B-610, General Policy

Body

Revision 15-4; Effective October 1, 2015

All Programs

Changes are situations that occur in a household that may affect eligibility or the amount of benefits. The advisor must take action on reported changes to ensure that:

- individual benefits are issued timely and accurately;
- the Texas Health and Human Services Commission (HHSC) is not sanctioned for failure to provide correct benefits for the correct month; and
- Quality Control (QC) initiatives are met.

B-620, Reporting Requirements

Body

Revision 24-3; Effective July 1, 2024

All Programs

During the certification period, households must report specific information based on the type of assistance and their household circumstances. Send Form H1019, Report of Change, to inform households of their reporting requirements.

B-621 What to Report

Revision 26-1; Effective Jan. 1, 2026

TANF

Inform all certified households of their responsibility to report changes in:

- physical address;
- the source of earned and unearned income;
- the amount of non-exempt unearned income of any household member;
- household composition;
- ownership of licensed vehicles;
- wage rate or employment status, meaning full-time or part-time as defined by the employer, for employed household members;
- available cash, stocks, bonds, or money in a bank account if the total is above $1,000;
- address, job, or other information about the absent parent;
- citizenship or immigration status; and

- circumstances other than employment that affect a person's benefit amount or employment services exemption status.

SNAP

Streamlined reporting (SR) minimizes the information that households must report during the certification period to maintain their benefit level and eligibility. Households are assigned an SR designation at application and redetermination. Both SR 1 and SR 2 households are subject to SR criteria, SR 3 households are not. At application and redetermination, inform all households of the changes they must report based on their SR designation. The household's SR designation does not alter the change reporting requirements for associated medical program(s) or TANF benefits.

SR households only must report changes based on their SR designation. However, staff must take appropriate action on any household reported changes and all agency-generated changes despite the SR designation.

SR 1 and SR 2 households do not need to report changes to their residence or associated changes in shelter costs such as rent or mortgage and utilities.

SR 1 Households

Inform SR 1 households of their responsibility to report changes in:

- income when ongoing gross monthly income exceeds 130 percent of the FPL for the household's size, for two consecutive months;
- work or participation hours of an able-bodied adult without dependents (ABAWD) if their hours decrease below an average of 20 hours per week; and
- lottery or gambling winnings of more than $4,250.

SR 2 Households

Inform SR 2 households of their responsibility to report changes in:

- income if ongoing gross monthly income stays above 130 percent of the FPL for the household's size, for two consecutive months;
- work or participation hours of an ABAWD if their hours decrease below an average of 20 hours per week; and
- lottery or gambling winnings of more than $4,250.

Note: SR 2 households do not have to report changes in ongoing gross monthly income below 130 percent of the FPL for the household size.

SR 3 Households

Inform SR 3 households of their responsibility to report changes in:

- physical address and associated changes in shelter costs, such as rent or mortgage and utilities;
- source of earned and unearned income;
- legal obligation to pay child support to or for a person outside the household;
- household composition;
- ownership of licensed vehicles;
- wage rate or employment status meaning full-time or part-time as defined by the employer, for employed household members;
- gross monthly household unearned income if the amount changes by more than $125 during the certification period;
- available cash, stocks, bonds or money in a bank account if the combined resources total $5,000 or more;
- work or participation hours of an ABAWD if their hours decrease to below an average of 20 hours per week; and
- lottery or gambling winnings of more than $4,250.

Medical Programs except TP 45

Inform all households of their responsibility to report changes in:

- physical address;
- intent to live in Texas;
- the people living in the home;
- income, including sources of income, regular hours worked and pay rate;
- Modified Adjusted Gross Income (MAGI) expenses;
- a child being institutionalized or dying; and
- medical insurance coverage.

Households do not have to report changes in tax status or tax relationships during the certification period because tax status and tax relationships are self-declared based on what the household expects to report on their federal income taxes.

TP 08 and TA 31

Inform all households of their responsibility to report changes in physical address, job or other information related to the absent parent.

Children on TP 56 and TP 32

Inform all households of their responsibility to report changes in available cash, stocks, bonds, or money in a bank account if the total exceeds:

- $3,000, for households with a member who is elderly or has a disability and meets relationship requirements; or
- $2,000, for all other households.

TP 40

Inform all households of their responsibility to report the termination of a pregnancy.

TP 45

Inform all households of their responsibility to report if the child no longer lives in Texas.

Related Policy

General Reminders, A-1510
Monitoring Questionable Management, A-1731
E&T Procedures, A-1822
ABAWD Work Requirement, A-1940
Length of Certification, A-2324
Streamlined Reporting Households, A-2350
Definition of Elderly, B-431
Definition of Disability, B-432
Claims, B-700

B-622 When to Report

Revision 26-2; Effective April 1, 2026

All Programs

During the interview or application processing, households must report required changes that occurred since the application was filed.

After certification, households must report required changes within 10 days after the household knows about the change.

TANF and SNAP

Households must report required changes that occurred between the interview and initial certification within 10 days.

Related Policy

Information Reported During Application Processing, B-116
What to Report, B-621

B-623 How to Report

Revision 24-3; Effective July 1, 2024

All Programs

Households can use a Form H1019, Report of Change, or a Form H1028, Employment Verification, to report a change. Household members or someone with knowledge of the household's circumstances may report changes by:

- using their Your Texas Benefits account;
- visiting a HHSC local office;
- calling 2-1-1;
- faxing to 877-447-2839; or
- mailing to:

Texas Health and Human Services Commission
PO Box 149024

Austin, TX 78714-9024.

Related Policy

Receipt of Duplicate Application, A-121.2
Receipt of Identical Application, A-121.3
Authorized Representative, A-170
Form TF0001 Required (Adequate Notice), A-2344.1

B-624 Receipts for Reported Changes

Revision 24-3; Effective July 1, 2024

All Programs

Households may request a receipt to document the change report for their records. The receipt includes the type of change and the date reported. If a household requests a receipt, send a:

- copy of the completed Form H1019, Report of Change; or
- Form H1800, Receipt for Application/Medicaid Report/Verification/Report of Change.

B-630, Processing Requirements

Body

Revision 24-3; Effective July 1, 2024

All Programs

When a change is reported, determine:

- the type of change reported;
- the date the change occurred;
- the date the change was reported;
- if the change is considered as verified upon receipt based on the source of the report;
- if additional verification is required to determine how the reported changes affect the eligibility determination;
- the date the verification was received, if applicable; and
- the effective date of the change.

When income is new or increases, also determine:

- the date of the first payment;
- the source of the income;
- any expected variation in pay amounts, including the number of hours and rate of pay; and
- pay frequency.

When a household requests to select a new authorized representative (AR), determine the appropriate case action using AR policy.

When a change is reported on an application form, the date HHSC staff become aware of the change is considered the date the change was reported.

TANF

If a household reports that a minor child is no longer in the home, determine if the change makes the household ineligible or requires a second parent to participate in CHOICES.

SNAP

When adding a household member, determine the primary wage earner and if the new person is subject to the Employment and Training (E&T) work requirement and the ABAWD work requirement. Ensure the Form TF0001, Notice of Case Action, informs the household about their SNAP work rules.

When adding a newborn child, determine the date the newborn joined the SNAP household after being released from the hospital.

When a person is removed from household, determine if any remaining household members become subject to the E&T work requirement and the ABAWD work requirement. Ensure the Form TF0001 informs the household about their SNAP work rules.

TP 45

Before adding a newborn child, determine if there is an existing Medicaid EDG by querying the mother's individual number or demographic information. This helps prevent duplicate medical coverage and individual numbers.

TP 43, TP 44 and TP 48

When a household with a child ,1 to 18, on an active Children's Medicaid EDG reports a new child, who is a sibling or non-sibling, the household does not need to complete a new application. Determine the new child's household composition and if the new child has any countable income.

TA 82, TP 40, TP 44 and TP 70

If a person's Medicaid is suspended because the person was incarcerated in a Texas county jail, determine if they can be added to an existing case for reinstatement of all previous benefits when the person's Medicaid is reinstated.

Related Policy

Authorized Representatives, A-170
Choices, A-1821
E&T Procedures, A-1822
Federal Time Limits, A-1900
Medicaid Suspension, B-520
Medicaid Reinstatement for Children Certified for TP 44 Released from a Juvenile Facility, B-531
Medicaid Reinstatement for Persons Released from Texas County Jails, B-532
Effective Date Requirements, B-640

B-631 Actions on Changes

Revision 24-3; Effective July 1, 2024

All Programs

Determine eligibility for multiple programs independently of each other. Do not deny a type of assistance based solely on the denial of another type of assistance. When the agency receives information, it can be used to meet verification requirements for multiple programs.

If additional verification is required, send the household a Form H1020, Request for Information or Action, and a Form H1020-A, Sources of Proof. The household is allowed 10 calendar days to provide the requested information or verification. The date on the Form H1020 is day zero of the 10 calendar day period.

If unverified income is reported that makes the household ineligible, request additional income verification.

After determining eligibility:

- send a new Form H1019, Report of Change, with a prepaid envelope to report future changes; and
- send a Form TF0001, Notice of Case Action. If the household fails to provide the required additional verification by the due date on the Form H1020, send the Form TF0001 by the next business day.

If a change of address is reported, send the household a form VR30, Texas Voter Registration Application.

TANF and Medical Programs

Regardless of if the household must report the change, staff must take action on all household-reported and agency-generated changes.

TANF and SNAP

If the reported change increases the household's monthly benefit allotment, issue supplemental benefits. If additional verification is received, issue supplemental benefits by the last day of the month the verification was received.

SNAP

Staff must take action on all household-reported and agency-generated changes when the available information is sufficient to process the change. Take action even when the change is not required to be reported because of the household's SR designation.

If additional verification is needed to process the change, only send Form H1020 when:

- the household's SR designation requires them to report the change, and the information is less than 60 days old from the first day of the month the change was reported;
- the reported information conflicts with the information used to certify the household at the most recent application, redetermination, interview, or previous report of change; or
- electronic data sources identify a household member may be deceased.

If a household or agency-generated change is reported and Form H1020 is not required, document the reported change in the case record and verify the information reported at the next redetermination.

At redetermination, consider information the household reported during the last benefit month which is effective after the certification period ends.

If a household member is subject to the E&T work requirement or the ABAWD work requirement, call the household to verbally explain their rights and responsibilities. Inform households with exempt members of their option to voluntarily participate in the SNAP E&T Program. Ensure Form TF0001 informs the household about their SNAP work rules.

When a child on an active EDG is placed in foster care, send Form TF0001 to give the household advance notice of adverse action.

Related Policy

Change in Medical Expenses During Certification, A-1428.4
Registering to Vote, A-1521
Adverse Action, A-2340
Streamlined Reporting Households, A-2350
Information Received During Application Processing, B-116
Actions on Agency-Generated Changes, B-631.2
Changes Increasing Benefits (Other than Additions to the Household), B-642
Changes Decreasing Benefits, B-643
Questionable Information, C-920

B-631.1 Actions Known to the Agency

Revision 24-3; Effective July 1, 2024

All Programs

When information is reported to HHSC, consider the information known to the agency. If required, take action on all active EDGs. Multiple changes reported on the same day must be processed as one occurrence. If required, send Form H1020, Request for Information or Action, with the corresponding pending period and list the verifications needed for all changes.

Multiple changes reported on different days must be processed as separate occurrences. Each change could affect the benefits for different months. If required, send Form H1020 for each reported change with the corresponding pending period and list only the verification needed for that change.

TANF

When a newborn is reported on an active TP 40 EDG and a TP 45 EDG is established, consider the information as known to the agency. Staff then takes action on the associated TANF EDG.

SNAP

When a newborn is reported on an active TP 40 EDG and a TP 45 EDG is established, consider the information as known to the agency and take action on the associated SNAP EDG. Before adding a newborn, the household must confirm the date the newborn joined the household.

Related Policy

Effective Date Requirements, B-640

B-631.2 Actions on Agency-Generated Changes

Revision 24-3; Effective July 1, 2024

All Programs

The Texas Department of Family and Protective Services (DFPS) notifies HHSC through an interface when a child receiving TANF, Medicaid or SNAP has been placed in foster care. The eligibility system automatically removes the child from the EDG(s). If the eligibility system does not remove a child placed in foster care, take action to manually remove the child from the EDG(s).

Do not add other children or siblings to a household when reinstating a denied EDG because a child was released from a juvenile facility or a county jail. The household must submit a new application to add other children or siblings.

The Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) notifies HHSC through an interface when a child certified for Medicaid is placed in a juvenile facility and when a child is released.

OIG staff help with clearing computer matches for the following reports:

- Public Assistance Reporting Information System (PARIS) Interstate Matches;
- Texas Department of Criminal Justice (TDCJ);
- Social Security Administration Prisoner Verification System (PVS);
- Income and Eligibility Verification Systems (IEVS); and
- Social Security Administration Deceased Individual Report.

PARIS Interstate Matches

When OIG staff receive an Interstate Match through PARIS that shows a person on an active TIERS EDG is receiving benefits in another state, OIG informs HHSC staff by creating a task within the Task List Manager (TLM). Take the appropriate action to process the task based on the information provided by OIG.

TDCJ and PVS Matches

When OIG staff find a match through TDCJ or PVS that shows a person on an active TIERS EDG is incarcerated, OIG informs HHSC staff by creating a task within TLM. Take the appropriate action to process the task based on the information provided by OIG.

When staff request a Data Broker report, TDCJ information is displayed on the combined report for an incarcerated person.

Income and Eligibility Verification Systems (IEVS)

The procedures for clearing IEVS reports are documented in C-1000, Procedures for Clearance of Income & Eligibility Reports & Internal Revenue Federal Tax Information.

Date of Death Matches

TIERS matches recipients on active EDGs with records from the Office of Inspector General (OIG), Social Security Administration (SSA), Texas Bureau of Vital Statistics (BVS), the Centers for Medicaid and Medicare Services (CMS), and HHSC Webservice to find deceased persons.

The BVS, if available is considered the primary source of verification of death. If BVS is available but the date of death (DOD) does not match reported information, accept BVS as verification. No additional verification is required.

If BVS verification is not available, verify the DOD using two of the following sources:

- SSA;
- statement from guardian or authorized representative;
- copy of death certificate;
- statement from a doctor;
- newspaper death notice (obituary);
- statement from a relative or household member;
- statement from a funeral director; or
- records from hospital or other institution where the person died.

TIERS attempts to update the DOD information for all active and inactive people and automatically removes them from active EDGs. If unable to process the death data automatically, TIERS creates a task for staff to research and confirm the validity of the computer match.

Take action to clear any discrepancies when DOD data is received on an active or inactive person within TIERS and TIERS is unable to automatically dispose the case. When TIERS cannot dispose the case, a series of alerts are created for staff to explore and request additional verification.

To clear discrepancies, request additional verification of the DOD data received. Do not require the household to provide the verification if the verification is available through one of the sources listed above.

Related Policy

Verification Sources, A-1081
Inmate/Parolee Match, C-825.17
Procedures for Clearance of Income & Eligibility IEVS, Reports & Internal Revenue IRS, Federal Tax Information FTI, C-1000

B-632 Mass Changes

Revision 15-4; Effective October 1, 2015

All Programs

The state or federal government initiates changes that can affect all individuals or large numbers of individuals. Individuals are not required to report mass changes. These changes occur in the:

- income eligibility standards;
- shelter and dependent care maximum deductions;
- Thrifty Food Plan and standard deductions;
- utility standard;
- cost-of-living adjustments for Social Security, Supplemental Security Income (SSI) and other federal benefits;
- TANF grants; and
- other eligibility criteria based on legislative or regulatory actions.

When these changes occur, HHSC automatically adjusts eligibility or benefits for most individuals and notifies the households via Form TF0001, Notice of Case Action. The adjustments are effective the date of the change. Advisors do not send Form TF0001.

HHSC generates an exception report for EDGs that are not adjusted during the state office conversion. Advisors must review the EDGs, adjust benefits if necessary, and send the individual Form TF0001, allowing advance notice of adverse action if required.

B-633 Changes in Eligibility Test

Revision 15-4; Effective October 1, 2015

All Programs except TP 45

If a household's circumstances change and the household is subject to a new income/resource test, the advisor must determine eligibility by applying the new test when the change is reported.

B-634 Changes in SNAP EDGs Jointly Processed with Supplemental Security Income (SSI)

Revision 15-4; Effective October 1, 2015

SNAP

Individuals whose SNAP and SSI applications have been jointly processed must report changes like other SNAP individuals.

B-635 Shortening Certification Periods as a Result of a Change

Revision 24-3; Effective July 1, 2024

SNAP

Shorten a certification period for a household designated as SR 3 when:

- A change occurs that makes the household’s circumstances unstable, and the effect of the change on the household's eligibility or benefits cannot be determined. This includes:
  - receipt of the discrepancy report Alert 254, Employer New Hire Data;
  - new listings of information on Data Broker that are inconsistent with information previously reported by the household; and
  - situations where a public assistance household's TANF is denied for an administrative reason, such as missed appointment, voluntary withdrawal or failure to provide information requested to redetermine TANF eligibility, and the household’s SNAP EDG becomes questionable.
- The household's eligibility becomes questionable as described in special reviews for known changes.

Send Form H1020, Request for Information or Action, requesting specific verification. If the SR 3 household does not provide the verification, deny the household for failure to provide information and send Form TF0001, Notice of Case Action.

Do not shorten the certification period if the household is designated as SR1 or SR 2.

Centralized Benefit Services (CBS) staff shorten certification periods when a household reports a change that results in the household being transferred out of CBS.

Related Policy

Setting Special Reviews, to determine when to set a special review on SR EDGs, A-2330
Due Dates, B-125.1
Special Procedures for Shortening Certification Periods for Centralized Benefit Services (CBS) Eligibility Determination Groups (EDGs), B-474.6.1
Data Broker, C-820
Questionable Information, C-920

B-636 Change in Head of Household (HOH)

Revision 24-3; Effective July 1, 2024

All Programs

When the current HOH dies or leaves the home, change the HOH to another responsible adult household member without requiring the remaining household members reapply for benefits. If there are children in the household, a responsible adult household member is:

- a parent with minor children living in the household; or
- an adult who has parental control over minor children living in the household.

If there is no responsible adult member identified in the household, and a child in the household is receiving benefits, send Form H1020, Request for Information or Action, to notify the household that a responsible adult who is caring for the child must apply for benefits for the child to continue to receive assistance. If an application is not submitted by the Form H1020 due date, deny benefits since the whereabouts of the household are unknown.

SNAP and TANF

If the HOH who left the home was the Electronic Benefit Transfer (EBT) primary cardholder (PCH), update the PCH information with the new HOH and issue a new Lone Star Card to allow the household access to SNAP and TANF benefits. Do not update the information if a new HOH has not been identified.

Related Policy

Establishing the Primary Cardholder, B-231
Issuing a Lone Star Card, B-233
PCH Replacements, B-237

B-637 Periodic Income Checks

Revision 24-2; Effective April 1, 2024

TP 08

Initiating a PIC requires no staff action. It uses the automated income check process to determine if there has been a change in the household's income that makes the household potentially ineligible for Medicaid for Parents or Caretaker Relatives.

A PIC is initiated in months three through eight of the certification period when the following conditions are met:

- any of the following is true for at least one person in the MAGI household for at least one countable income or expense source:
  - an income or expense is not verified;
  - one of the following income types uses "Verified by Reasonable Compatibility" as the verification source:
    - employment income;
    - unemployment compensation income; or
    - RSDI income; or
  - the verification source is anything other than "Verified by Reasonable Compatibility" and the verification received date is more than 60 days old; and
- the case is in Approved Ongoing mode; and
- there are no pending TLM tasks for the case.

The household's income information in the eligibility system is compared with income data available through electronic data sources (ELDS) as part of the automated income check process. This is to determine if it is reasonably compatible, as explained in A-1370, Verification Requirements, Medical Programs.

The eligibility system may be able to complete the entire PIC process without any staff action or correspondence sent to the client. This is if the PIC does not find an indication that there has been a change in the household's income that makes them potentially ineligible.

Electronic income data is requested one month before the eligibility system uses it. If the household's income is not determined to be reasonably compatible with electronic data, the household must provide other acceptable verification as explained in A-1371, Verification Sources.

Electronic Data Hierarchy for Earned Income

1. TIERS checks electronic data from the Texas Workforce Commission (TWC).
2. If earned income electronic data is not available, TIERS checks to see if there is a New Hire Report. When a New Hire Report exists that does not match the household's income information in TIERS, the household must provide verification of the information on the New Hire Report.

TIERS also checks SOLQ to verify RSDI income (unearned income).

Process verifications returned as the result of a PIC following changes policy. If the person does not provide the requested verification by the 10th day, TIERS automatically sends Form TF0001 on the 11th day for failure to provide.

SNAP and TANF

Verification is required for SNAP and TANF during the automated income check process when:

- The reasonable compatibility calculation result is Need Info because ELDS above limit or the person is required to provide verification of information found on a New Hire Report for a Medical Program.
- A person in the MAGI household is included in a SNAP or TANF budget group.

The person has 10 days to provide the verification for SNAP and TANF. If the person does not provide verification by the 10th day, TIERS will automatically take the following action on the 11th day based on the income type and electronic data source used during the automated income verification process:

- **Deny** SNAP and TANF benefits for the following data sources:
  - quarterly wage data from the TWC; or
  - New Hire Report data from the Office of the Attorney General (OAG).
- **Create a task to notify staff to adjust** SNAP and TANF benefits for the following data sources:
  - unearned Retirement, Survivors, and Disability Insurance (RSDI) income data from the Social Security Administration Social Security Administration (SSA); or
  - unearned unemployment data from TWC.

Note: Unearned RSDI data from SSA, or unearned unemployment data from TWC are valid forms of verifications for SNAP and TANF. Since quarterly wage data from TWC and New Hire Report data from OAG are not valid sources of verification for SNAP and TANF, the person must provide verification of the income.

Related Policy

Medicaid Termination, A-825
Advance Notice, A-2343
Actions on Changes, B-631
Employer New Hire Report (ENHR) and National Directory of New Hires (NDNH) Report, C-825.12
Texas Workforce Commission (TWC) Wages/Benefits, C-825.13
Expedited CHIP Enrollment, D-1711

B-638 Returned Mail

Revision 24-3; Effective July 1, 2024

All Programs

Staff must take the following action when returned mail is received:

If the case includes an active SNAP EDG:

1. Review the address shown on the returned mail, the case record, and the State Portal to determine if the household has reported a new address. If a new address was reported, process the address change and any related changes in shelter expenses. Otherwise, go to Step 2.
2. If the new address was not reported and a forwarding address was not provided, make one attempt to contact the household by phone to confirm the address and document the attempt. If able to contact the household and the household provides a new address, process the change and any related changes in shelter expenses. Otherwise, go to Step 3.
3. If the returned mail is a SNAP redetermination packet and there are no other active EDGs, document these facts in Texas Integrated Eligibility Redesign System (TIERS) Case Comments and take no further action. Otherwise, go to Step 4.
4. If unable to contact an SR 1 or SR 2 household by phone to get an updated address, document the returned mail in the case record and verify the household's address and any change in shelter expenses at the next redetermination. If unable to contact an SR 3 household by phone to get an update on their address, send Form H1020, Request for Information or Action, to the TIERS address to request verification of address and any change in shelter expenses.
5. If the returned mail shows a new out-of-state address for the SR3 household, send Form H1020 to request additional verification of physical address, residency, and duplicate participation.
6. If the SR 3 household fails to provide the requested information on Form H1020, send Form TF0001, Notice of Case Action, and deny the household for failure to provide information.
7. If the SR 3 household is denied for failure to provide information and provides a correct address within the advance notice of adverse action period, reopen the EDG using the original certification period and process any related changes in shelter expenses.

If the case does not include an active SNAP EDG:

1. Review the address on the returned mail, the case record, and the State Portal to determine if the household has reported a new address. If a new address has been reported, process the address change. Otherwise, go to Step 2.
2. If a new address has not been reported and a forwarding address was not provided, make one attempt to contact the household by phone to get an update on their address and document the attempt. If the household provides a new address, process the change. Otherwise, go to Step 3.
3. If unable to contact the household by phone to get an updated address, send Form TF0001 and deny the EDG for being unable to locate.

Related Policy

Form TF0001 Required (Adequate Notice), A-2344.1
Actions on Changes, B-631
Returned Mail, E-2221
Returned Mail, M-2221

B-640, Effective Date Requirements

Body

Revision 24-3; Effective July 1, 2024

All Programs

The effective date of the change is based on the date the change is reported and the date the verification is provided.

When a change is reported on an application form, the file date is considered the report date to determine the effective date of the change. The date HHSC staff begin working the EDG and become aware of the change is day zero for purposes of taking action on the change for the associated EDGs.

When a change is reported during the last benefit month and is effective after the certification period ends, do not send the household a Form H1020 or Form H1020-A.

B-641 Additions to the Household

Revision 24-3; Effective July 1, 2024

All Programs

Confirm the household addition does not currently receive benefits in Texas or any other state or territory.

All changes associated with a person at the time they join a household affect the household's eligibility and benefit allotment for the same month, even if the change is reported on a different day.

TANF and SNAP

If the addition to the household causes benefits to increase or remain the same, send Form TF0001, Notice of Case Action, by the 10th day after the change is reported.

If the household addition is a member of another active SNAP or TANF household, remove the person from the previous household before adding the person to the new household. If adding the person increases the new household's benefit allotment and the person was not removed from the previous household in a timely manner, issue restored benefits to the new household and file an overpayment referral on the previous household.

When an active household reports the addition of a new member who is disqualified, add the new member effective the month after the disqualification ends.

Medical Programs except TP 45

Under MAGI household composition rules, a person joining or leaving the home may or may not affect eligibility depending on that person's tax status, tax relationships and family relationships.

However, if multiple households self-declare the same person as a tax dependent, staff must clear the discrepancy with all households attempting to claim the same person as a tax dependent. Staff then update the tax statuses of each household as a change, if necessary.

TP 08

When an additional legal parent or caretaker relative is added to a household with an active TP 08 EDG, certify the new adult on a separate EDG. The system aligns the certification period of the newly created EDG with the existing TP 08 certification period.

Assign a Medicaid eligibility date as early as three months before the month the person reports the change for applicants who have unpaid medical bills and meet the criteria for Medicaid coverage for the months before the month of application. When applying the criteria, the application month is the month the person reports the change.

TP 43, TP 44 and TP 48

When a child is added to a household with an active Children's Medicaid EDG, certify the new child on a separate EDG. The system aligns the certification period of the newly created EDG with the existing child's Medicaid certification period.

Assign a Medicaid eligibility date as early as three months before the month the person reports the change for applicants who have unpaid medical bills and meet the criteria for Medicaid coverage for the months before the month of application. When applying the criteria, the application month is the month the person reports the change.

Related Policy

Receipt of Application, A-121
Who Is Not Included, A-222
Disqualified Persons, A-232.2
Medical Programs, A-240
Regular Medicaid Coverage, A-820
Medicaid Coverage for the Months Prior to the Month of Application, A-830
Employment Services, A-1800
E&T Procedures, A-1822
Processing Requirements, B-630
Filing an Overpayment Referral, B-770

B-641.1 Adding Newborns to the Case

Revision 24-3; Effective July 1, 2024

TANF and Medical Programs

Add newborns to the household even if they are still hospitalized as long as a parent exercises care and control and intends to bring the newborn home.

TANF

Add newborns to the household effective the date the change was reported.

SNAP

Add newborns effective the date the newborn joins the household after being released from the hospital. For newborns with associated TP 45 EDGs, use the TP 45 eligibility begin date as the date the change was reported.

Before adding a newborn, the household must attest to the date the newborn joined the household. Contact the household by phone and get any additional verification required for the associated TP 45 EDG. If unable to contact the household, send Form H1020 to request the required additional verification. When adding a child six months or younger, do not request additional verification for a social security number (SSN) or SSN application.

If verification that the newborn joined the household is not received by the due date on the Form H1020, Request for Information or Action, do not add the child to the SNAP EDG.

If the household later provides the required additional verification, add the newborn effective the month after verification is received.

Medical Programs

Add the newborn to the household effective, the newborn's date of birth.

Related Policy

General Policy, A-410

B-641.2 Steps for Adding New Members

Revision 24-3; Effective July 1, 2024

All Programs

If the change is:

- **Timely reported and verified,** add the new member to the case the month after the change occurred unless benefits decrease. If benefits decrease, send Form TF0001, Notice of Case Action. Decrease or deny benefits effective the month after notice of adverse action expires.
- **Untimely reported with timely verification,** add the new member effective the month after the change is reported. If the change decreases benefits, send Form TF0001. Decrease or deny benefits effective the month after notice of adverse action expires.
- **Timely or untimely reported with a delay in verification of eligibility points that results in individual disqualification, such as SSN or alien status, and verification is not provided by the Form H1020 due date**, take the following actions:
  - For TANF, if the new member is a required member of the certified group, disqualify the new member following applicable policy. Notify the household on Form TF0001 as appropriate. **Exception:** Refer to TANF policy for household members who are not required members of the certified group.
  - For SNAP, disqualify the new member following applicable policy. Notify the household of the disqualification on Form TF0001 as appropriate.
  - For Medical Programs, refer to reasonable opportunity policy.
- **Timely or untimely reported with enough information to determine benefits will decrease, but verification is delayed,** send Form TF0001 and decrease or deny benefits based on the person's unverified statement effective the month after notice of adverse action expires.
- **Timely or untimely reported lacking enough information about income, resources, or other factors necessary to determine eligibility or benefits,** send Form H1020 and Form H1020-A to request verification the same day the change was reported or no later than the next business day. Attempt to contact the household by phone within 10 days after the change is reported to get enough information to determine the effect of the change.
  - If information is obtained, change policy applies as described in this section.
  - If information is not obtained, the impacted EDGs remain pended until the Form H1020 due date.
  - If verification is not received by the Form H1020 due date, send Form TF0001 the next business day to deny the EDG for failure to provide information.

TANF

Delays in verification of other legal requirements for required members: If the new member is a required member of the certified group and the household does not provide proof of age, relationship or domicile by the Form H1020 due date:

- because it is not available, send Form TF0001 to notify the household that the person cannot be added without required verification.
- but it is available, send Form TF0001 to deny the EDG for failure to provide information.

Delays in verification for people who are not required members of the certified group: If the new member is not a required member of the certified group, and the person fails to provide requested proof by the Form H1020 due date, send Form TF0001 to notify the household that the new person cannot be added without required verification. If the household later provides verification, add the member effective the month after the verification is received.

SNAP

Request a combined Data Broker report for a new adult member.

Related Policy

Reasonable Opportunity, A-351.1
E&T Procedures, A-1822
Voluntary E&T Participants, A-1822.2
Action in Full-Service Choices Counties or E&T Counties, A-1831
Changes Decreasing Benefits, B-643

B-642 Changes Increasing Benefits (Other than Additions to the Household)

Revision 24-3; Effective July 1, 2024

All Programs

Advisors determine the effective dates of a change based on the date the change is reported and the date the verification is provided, as explained in B-642.1, Verification Provided Timely, and B-642.2, Verification Not Provided Timely. If supplemental benefits are necessary, the advisor must request the issuance by last day of the month that the verification is received. If verification is not required, the change is treated the same as if verification was received timely.

Related Policy

Verification Provided Timely, B-642.1
Verification Not Provided Timely, B-642.2

B-642.1 Verification Provided Timely

Revision 24-3; Effective July 1, 2024

All Programs

If the household provides verification of a reported change by the due date on the Form H1020, Request for Information or Action (PDF), increase benefits effective the month after the change is reported, regardless of if the change was reported timely. Send Form TF0001, Notice of Case Action, the next business day but by the business day after the Form H1020 due date.

If the household reports a change on an application form, use the file date as the report of change date. The household must provide the verification by the Form H1020 due date to be considered timely verification.

B-642.2 Verification Not Provided Timely

Revision 26-2; Effective April 1, 2026

All Programs

If the household fails to provide timely verification, do not increase benefits until verification is received. Send Form TF0001, Notice of Case Action, by the next business day after the Form H1020, Request for Information or Action, due date. Explain that benefits remain the same. If the household provides verification untimely, increase benefits effective the month after the verification is received.

If the household fails to provide verification before the next SNAP or TANF redetermination, request the verification again during the interview process. Deny the EDG if verification is not provided.

SNAP

If decreased or denied TANF or Refugee Cash Assistance (RCA) benefits result in an increase in SNAP benefits, benefits are increased the same month the TANF or RCA is decreased, with some exceptions.

Continue to budget the TANF or RCA grant in the SNAP EDG If the household appeals the TANF or RCA decision and receives continued TANF or RCA benefits.

Related Policy

Temporary Assistance for Needy Families (TANF), A-1324.18

B-643 Changes Decreasing Benefits Other than Removing Household Members

Revision 24-3; Effective July 1, 2024

TANF and SNAP

Staff must take action on changes shown in the chart below. Benefits are decreased or denied effective the month after the notice of adverse action expires. If applicable, file an overpayment referral. Refer to the TANF and SNAP Overpayment Determination Chart to determine the first month of an overpayment.

If a household reports a change	then
and provides all verification,	send Form TF0001, Notice of Case Action, by the 10th day after the change was reported* to decrease or deny benefits. send Form H1020, Request for Information or Action (PDF), and Form H1020-A, Sources of Proof (PDF), the same day the change was reported or no later than the next business day to request verification.**
with enough information to determine eligibility or benefit issuance but does not provide verification,	Send Form TF0001 to decrease or deny benefits based on the individual's unverified statement at the time the change was reported: • by the 10th day after the change was reported;* or • with Forms H1020 and H1020-A if the change was reported untimely. Require verification of the change at the next TANF or SNAP redetermination. **Note:** Verify income even if the amount reported makes the household ineligible.
without enough information to determine eligibility or benefit issuance,	send Form H1020 and Form H1020-A the same day the change was reported or no later than the next business day to request verification.** Attempt to contact the household by phone to get enough information to send Form TF0001 by the 10th day after the change was reported.* **Note:** The regional director may opt out of the requirement to make a phone contact. If information **is not** obtained to redetermine eligibility, the EDG remains pended until the Form H1020 due date. If verification is not received by the Form H1020 due date, send Form TF0001 the next business day and deny the EDG for failure to provide verification. **Exception:** If the household fails to provide verification of a deductible expense that requires verification, disallow the deduction instead of denying the EDG. Follow verification requirement policy to determine if any deduction is allowable for the expense.

* If the due date for sending Form TF0001 falls on a non-business day, send it the preceding business day to meet the 10-day requirement.

** Allow the person 10 days to provide the verification requested on Form H1020. If the 10th day falls on a non-business day, use the following business day as the due date. **Note**: Use change policy for situations where the Texas Department of Family and Protective Services (DFPS) places a TANF or Medicaid child in foster care.

TP 08

If a person or electronic data source indicates new or increased earned income, alimony, or spousal support that makes the person ineligible, send Form H1020 to request additional verification of the income. If the person fails to provide verification of the earned income, alimony or spousal support, deny the EDG and open the appropriate Transitional Medicaid EDG (TP 07 or TP 20) if:

- the information is not questionable; and
- the person meets the eligibility requirements for the applicable Transitional Medicaid EDG.

In addition, deny the Medicaid EDG and open the appropriate Transitional Medicaid EDG for each associated parent or caretaker and dependent child.

Related Policy

General Eligibility Information, A-841
TP 07 Transitional Medicaid, A-842
TP 20 Alimony/Spousal Support Transitional Medicaid Coverage, A-850
Verification Requirements, A-1440
Denial at Redetermination, A-2342
Actions on Changes, B-631
Claims, B-700
TANF and SNAP Overpayment Determination Chart, C-1140

B-650, Correcting Incorrect Information

Body

Revision 24-3; Effective July 1, 2024

All Programs

People have a right to correct any information that HHSC has about them or any other household member on their case.

Refer to the appropriate application, redetermination or change policy for the time frames and procedures to correct or update information.

Related Policy

Case Disposition, A-2300
Processes and Processing Time Frames, B-100
Changes, B-600

B-651 Correction Request

Revision 24-3; Effective July 1, 2024

All Programs

A household must submit a written request for correction and:

- identify the person asking for the correction;
- identify the disputed information about the person;
- state why the information is wrong;
- include any verification that confirms the information is wrong;
- state what correction is requested; and
- include a return address and phone number, or email address, where HHSC can contact the person.

Do not require households to request correction of incorrect information in writing during application, redetermination, and other actions on active EDGs.

Related Policy

Information Reported During Application Processing, B-116
Processing Untimely Redeterminations, B-124
How to Report, B-623

B-652 Action on Denied EDGs or EDGs During their Last Month of Certification When the Client Has Not Reapplied

Revision 24-3; Effective July 1, 2024

All Programs

Respond according to the following chart:

When a person requests the agency correct their information	then
at application, redetermination or anytime an EDG is active,	follow policies in A-2300, Case Disposition, B-100, Processes and Processing Time Frames, and B-600,

When a person requests the agency correct their information	then
	Changes.
on a denied EDG or during the last month of certification, and the person has not reapplied,	• review the request; • contact third parties if necessary; and • send the correct information for imaging.

Notify the household in writing within 60 days on current HHSC letterhead without the board members' names. Show if the information has been corrected or will not be corrected and the reason. Inform the household if HHSC needs to extend the 60-day period by an additional 30 days to complete the correction process or obtain additional information.

If HHSC makes a correction to personally identifiable health information, ask the person for permission before sharing with third parties. HHSC will make a reasonable effort to share the correct information with people who received the incorrect information from HHSC if they may have relied or could rely on it to the disadvantage of the household. Follow procedures to contact the HHSC privacy officer for a record of disclosures.

Note: Follow procedures to establish a claim or restore benefits if an overissuance or underissuance occurred. Make a referral to the Office of Inspector General for intentional program violations.

Related Policy

IRS FTI Security and Protection, C-1050

B-653 Different Review Process

Revision 24-3; Effective July 1, 2024

All Programs

Do not follow change policy when the accuracy of information provided by a person is determined by another review process such as:

- fair hearing;
- civil rights hearing; or
- other appeal process.

The decision in that review process is the decision on the request to correct information.

Related Policy

Fair Hearings, B-1000

B-660, Documentation Requirements

Body

Revision 24-3; Effective July 1, 2024

All Programs

Document the:

- reported change;
- date the change occurred;
- date the change was reported; and
- date the verification is provided.

For new income changes, document the date of the first payment.

For address changes, document providing the household with form VR30, Texas Voter Registration Application, and Form H1350, Opportunity to Register to Vote.

SNAP

Document:

- the reason for shortening certification as a result of a change.
- that the person failed to provide required verification to add a newborn certified for TP 45 to their SNAP EDG.

If a household or agency-generated change is reported and the Form H1020 is not required to be sent, document the reported change in the case record. Verify the information reported at the next redetermination.

Medical Programs

Document a change in tax status or relationship in case comments. Address the change at the next redetermination.

TP 08

Document the reason for denying a TP 08 EDG and opening a TP 07 EDG when new or increased income makes the household ineligible.

Related Policy

Documentation Requirements, A-1380
Registering to Vote, A-1521
Actions on Changes, B-631
Shortening Certification Periods as a Result of a Change, B-635
Adding Newborns to the Case, B-641.1
Documentation, C-940
The Texas Works Documentation Guide (PDF)

B-700, Claims

B-710, General Policy

Body

Revision 11-1; Effective January 1, 2011

All Programs

An overpayment is the amount of benefits issued in excess of what should have been issued.

A claim is an amount owed by an individual for an overpayment of benefits or owed by an individual for benefits that are trafficked.

The date of discovery is the date the Office of Inspector General (OIG) substantiates that an overpayment occurred.

B—711 Types of Overpayment Claims

Revision 15-4; Effective October 1, 2015

All Programs

There are three types of overpayment claims:

- agency error,
- inadvertent household error/misunderstanding, or
- fraud or intentional program violation (IPV).

OIG staff process overpayment referrals, determine the overpayment amount, and submit as a claim to the Texas Health and Human Services Commission (HHSC) Fiscal Management Services (FMS) to collect.

Related Policy

Referrals for Intentional Program Violation (IPV), B-900

B-720, When to File an Overpayment Referral

Body

Revision 19-4; Effective October 1, 2019

All Programs

Staff must file an overpayment referral when a household receives benefits the household is not entitled to receive. When an overpayment occurs, OIG establishes the claim. The household must repay any type of overpayment claim.

If the household reports a change and staff does not take the appropriate action or fail to act on an agency-generated change, an overpayment referral must be filed.

Do not file an overpayment referral if the overpayment was due to:

- a change the household is not required to report; or
- an overpayment that occurred more than six years before the date of discovery.

SNAP

Changes for categorically eligible households, except for changes in net income, household size or both, do not cause an overpayment.

Exception: This does not apply to households who are categorically eligible based on receipt of Temporary Assistance for Needy Families - Non-Cash (TANF-NC).

OIG files a claim when an intentional program violation (IPV) is established against a person for trafficking Supplemental Nutrition Assistance Program (SNAP) benefits or accessing devices such as Electronic Benefit Transfer (EBT) cards.

B-730, How to File an Overpayment Referral

Body

Revision 15-4; Effective October 1, 2015

All Programs

When an overpayment occurs, advisors determine the type of overpayment and enter an overpayment referral using the Automated System for Office of Inspector General (ASOIG) or the Texas Integrated Eligibility Redesign System (TIERS) referral interface. See B-770, Filing an Overpayment Referral, for overpayment referral instructions.

B-740, Texas Works Responsibilities

Body

Revision 23-1; Effective Jan. 1, 2023

All Programs

Texas Works staff:

- identify overpayments;
- enter all agency error, inadvertent household error or misunderstanding, and fraud overpayment referrals using ASOIG or the TIERS referral interface, within 30 days of the date a potential overpayment is identified;
- process fair hearing requests about claims establishment or collection using the TIERS interface; and
- forward any payments or warrants received at the local office, along with a copy of Form H4100, Money Receipt, within 24 hours of receipt to:

  Texas Health and Human Services Commission
  Fiscal Management Services
  ARTS Billing
  P.O. Box 149055
  Austin, TX 78714-9055

The Accounts Receivable Tracking System (ARTS) is administered by FMS staff who monitor and process payments from people who receive HHSC services. The ARTS Hotline number is 800-666-8531.

B—741 Texas Works Action on Agency Errors

Revision 11-1; Effective January 1, 2011

TANF and SNAP

When an agency error overpayment occurs, Texas Works staff:

- correct the ongoing benefits, as needed, using adverse action procedures; and
- enter an electronic overpayment referral using ASOIG or the TIERS referral interface within 30 days of the date a claim is identified.

Note: See B-770, Filing an Overpayment Referral, for instructions about how to complete and send an overpayment referral.

B—742 Texas Works Action on an Inadvertent Household Error/Misunderstanding or Intentional Program Violation (IPV)

Revision 15-4; Effective October 1, 2015

All Programs

When an overpayment is due to an inadvertent household error/misunderstanding or a potential IPV, Texas Works staff:

- correct the ongoing benefits, as needed, using adverse action procedures; and
- enter an overpayment referral using ASOIG or the TIERS interface within 30 days of the date a claim is identified.

Note: See B-770, Filing an Overpayment Referral, for instructions about how to complete and send an overpayment referral.

When an alien and the alien's sponsor are liable for an overpayment, both individuals are referred to the OIG.

The alien and the alien's sponsor are not referred for an overpayment claim if the sponsor also receives benefits in the same program in which the alien’s overpayment occurred.

B-750, Office of Inspector General (OIG) Responsibilities

Body

Revision 23-1; Effective Jan. 1, 2023

All Programs

The OIG Benefits Program Integrity (BPI) department investigates allegations of recipient non-fraud overpayment and fraud. The BPI department consists of the claims investigation and field investigation units located throughout the state.

B-751 Office of Inspector General (OIG) Investigation Staff

Revision 19-4; Effective October 1, 2019

All Programs

OIG staff:

- screen all types of referrals and investigate valid agency error, inadvertent household error or misunderstanding, fraud, IPV, individual or retailer EBT trafficking, and employee fraud;
- process referrals including initiation of demand letters and establishment of claims;
- set restitution or recoupment amounts for active Eligibility Determination Groups (EDGs);
- respond to follow-up questions from people who receive benefits and staff about the validity of claims;
- coordinate with Texas Works staff to process fair hearing requests related to claims establishment or collection; and
- initiate the process to debit an EBT food account to repay a SNAP claim when the request is made.

Related Policy

Texas Works Responsibilities, B-740
Texas Works Action on an Inadvertent Household Error/Misunderstanding or Intentional Program Violation (IPV), B-742
Texas Works Action on Agency Errors, B-741

B-752 Determining Claim Amounts

Revision 15-4; Effective October 1, 2015

All Programs

OIG staff take the following steps when determining claim accounts:

- determine the first month of overpayment (see B-752.1, Determining the First Month of Overpayment);
- exclude any months in which the household did not receive benefits or benefits were expunged;
- follow applicable policy in A-1300, Income, to budget the overpayment months;
- budget each month of an overpayment by using actual income amounts received for the month (the income is not converted);

  Exceptions: OIG staff:
  - budget the income originally projected at certification/redetermination when the income does not involve a required change; and
  - budget earned income as reported quarterly to the Texas Workforce Commission (TWC) to determine the overpayment amount when all efforts to verify earned income amounts have been exhausted; allow the household the opportunity to provide verification of actual gross pay per pay period; and recompute the overpayment if the individual provides the verification. **Note:** For cases sent to an administrative disqualification hearing, staff must verify the employment hire date when computing an overpayment based on TWC wage information.
- do not allow earned income deductions for any earned income that the household failed to report timely as required and this failure caused an overpayment (deductions for overpayment months caused by an agency error are allowed);
- for excess resource overpayment EDGs, compute earned interest income to estimate an account balance for the tax year, as reported annually by the Internal Revenue Service (IRS) through the Income and Eligibility Verification System (IEVS), to determine the overpayment amount when all efforts to verify an unreported financial institution account have been exhausted; allow the household the opportunity to provide verification of the interest income and the resource; and recompute the overpayment if the individual provides the verification;
- subtract the amount the household was entitled to receive from the amount the household actually received before recoupment;

  Exception: There is no recoupment for Medical Programs.

- total all the monthly amounts of overpayment; and
- when the household is due unpaid restored benefits, offset the amount to be restored against the overpayment amount and document the offset according to B-831, Procedures for Counting Restored Benefits Toward a Claim.

Related Policy

Computing Benefits by EDG Action Type, A-1357
Reporting Requirements, B-620

TANF

When a child support payment was made during the overpayment month, the total income, less the $75 disregard, is counted to determine the overpayment amount.

B-752.1 Determining the First Month of Overpayment

Revision 11-1; Effective January 1, 2011

B-752.1.1 Errors at Certification

Revision 11-1; Effective January 1, 2011

All Programs

The first month of overpayment is the first month the household received more benefits than it was entitled to receive.

B-752.1.2 Errors After Certification

Revision 15-4; Effective October 1, 2015

All Programs

The first month of overpayment for non-streamlined reporting (SR) households is the month in which the change would have been effective had it been reported and acted on in a timely manner. However, the first month of overpayment can be no later than two months from the month the change occurred. Staff may use the following chart to determine the first month of overpayment.

If a change was...	then the first month of overpayment is the month that begins more than...
reported timely,	23 days after the date the change was reported. (Example: Change occurred January 5 and was reported January 10. Count 23 days to February 2. March is the first month of overpayment.)
not reported timely,	33 days after the date the change occurred. (Example: Change occurred January 5. Count 33 days to February 7. March is the first month of overpayment.)

Exception: The first month of overpayment may be earlier for errors caused by moves out of state. The first month of overpayment may be as early as the month after all members of the household leave the state and there is duplicate participation in that month.

Charts in C-1140, TANF and SNAP Overpayment Determination Chart, provide help for determining the first month of overpayment for both timely and untimely change reports.

SNAP

An overpayment does not exist on a streamlined reporting EDG unless:

- the household fails to timely report a required change, or
- the agency fails to timely act on a reported change.

Note: The 10-day reporting requirement for SR EDGs is from the first payment that exceeds the 130 percent Federal Poverty Income Limit (FPIL) threshold. For example, an individual receives a pay raise effective May 15. The individual's gross monthly income exceeds the 130 percent FPIL with the June 27 paycheck. The household must report the change within 10 days of June 27 to be timely.

The first month of overpayment is the month after the second month the income exceeds the 130 percent FPIL for the household size. For example, income exceeds the 130 percent FPIL on June 27 and for the month of July. August is the first month of overpayment.

Related Policy

Reporting Requirements, B-620

B-753 Establishing Claims

Revision 13-3; Effective July 1, 2013

B-753.1 Identifying Liable Members

Revision 22-3; Effective July 1, 2022

TANF, One-Time TANF and One-Time TANF for Relatives

Determine the liable household member responsible for repayment of a claim in the following order:

- Caretaker or payee.
- Second parent, spouse, or stepparent who was an adult household member at the time of the overpayment.

SNAP

Determine the liable household member responsible for repayment of a claim in the following order:

- The head of household.
- Any household member who was an adult at the time of overpayment.

TANF and SNAP

An authorized representative (AR) is liable for paying a claim when the AR causes an overpayment or traffics in SNAP benefits.

Sponsors and eligible aliens are jointly liable for overpayments resulting from incorrect information provided by the sponsor unless the sponsor:

- can show good cause;
- can show the eligible alien or sponsor was not at fault for the error; or
- receives benefits in the same program in which the overpayment occurred.

The sponsor, alien or both may appeal the amount or fault of an overpayment.

B-753.2 Demand Notices

Revision 19-4; Effective October 1, 2019

TANF and SNAP

OIG staff send either Form OIG 5034, Notice of SNAP Overpayment Claim, or Form OIG 5039, Notice of TANF Overpayment Claim or both, along with Form OIG 5027, Repayment Agreement, to the household.

To be timely, OIG staff must send the notice no later than 180 calendar days from the date the investigation was created in the Automated System for Office of Inspector General (ASOIG).

When the case involves an alien with a sponsor, OIG staff send separate demand notices to the alien and the alien's sponsor. The demand notice informs the sponsor that the sponsor is not responsible for the person when:

- the sponsor has good cause for the error;
- is not at fault; or
- receives benefits in the same program that the alien's overpayment occurred.

Note: Calls about overpayment demand notices are referred to the local OIG unit for clearance. Local office contacts can be found by clicking on this link: OIG Facilities Local Office Contacts.

After navigating to the website, click on "OIG Facilities Local Office Contacts" on the right side of the page.

B-753.3 Claim Disposition

Revision 19-4; Effective October 1, 2019

TANF and SNAP

OIG staff mail a household a repayment agreement notice and an overpayment claim notice. A claim in the *Accounts Receivable Tracking System* (ARTS) is then established the same date of the notice.

The claim notice provides:

- an explanation of how the overpayment claim amount was calculated;
- repayment options (either restitution or recoupment); and
- information about the person's right to request a fair hearing within 90 days of the effective date of claim notice.

The person indicates whether they prefer to repay the claim by restitution or recoupment on the repayment agreement notice and must return the agreement within 30 days of receipt.

Repayment of the claim is delayed only when the person requests a fair hearing.

B-760, Fiscal Management Services - Accounts Receivable Responsibilities

Body

Revision 19-3; Effective July 1, 2019

All Programs

HHSC Accounts Receivable staff:

- maintain the Accounts Receivable Tracking System (ARTS);
- manage the billing and collection process;
- manage delinquent claims;
- renegotiate methods of collection;
- modify existing claims;
- respond to inquiries from individuals or staff from the date the claim is established, including:
  - delinquent notices;
  - collection efforts;
  - federal payment intercepts through the Treasury Offset Program; and
  - license suspensions;
- process fair hearing requests related to claims establishment or collection (if the request is past 90 days from the claim origination date); and

- initiate the process for one-time debits of an EBT food account to repay a SNAP claim when the request is made after the claim is established.

B—761 Claims Collection

Revision 11-1; Effective January 1, 2011

B—761.1 Recoupment

Revision 19-3; Effective July 1, 2019

TANF and SNAP

Recoupment, also known as allotment reduction, is a method of recovering an overpayment claim by withholding a portion of the household's benefits.

B—761.1.1 Action on Recoupment Cases

Revision 20-2; Effective April 1, 2020

TANF and SNAP

Recoupment is initiated when Office of Inspector General (OIG) staff enter a claim against a household into the Accounts Receivable Tracking System (ARTS). ARTS interfaces with TIERS to automatically reduce the household's benefit allotment if any liable household member is currently receiving benefits.

Overpayments are recouped from all identified liable household members. When persons liable for an overpayment currently reside in separate households, overpayments are recouped from all liable household members until all claims are paid in full. When a liable household member is currently disqualified but on an active case, overpayments are recouped from the household benefit allotment received by the other certified members.

Follow policy in B-761.2.1, Action on Restitution Cases, if there is no liable household member currently receiving benefits to recoup from.

If a liable household member begins receiving benefits, TIERS automatically begins the recoupment process from the new benefit allotment. TIERS continues to recoup the newly certified benefits until the claim is paid in full.

Notes:

- HHSC Accounts Receivable staff may negotiate a repayment agreement with the household. However, if a claim is being recouped or has been sent to the U.S. Treasury for collection, HHSC Accounts Receivable will not enter into a new repayment plan.
- HHSC Accounts Receivable staff are authorized to make corrections to the recoupment records in ARTS.

Recoupment information is available through TIERS inquiry, ARTS inquiry, or by calling the Accounts Receivable Customer Service Hotline at 800-666-8531.

Related Policy

Identifying Liable Members, B-753.1
Recoupment Amount, B-761.1.3
Action on Restitution Cases, B-761.2.1

B—761.1.2 Recoupment Hierarchy

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Claims are recouped by error type in the following order.

1. Type A — IPVs (fraud)
2. Type J — inadvertent household error/misunderstanding
3. Type L — agency error

All three claim types can be simultaneously stored on ARTS. Recoupment of a Type A claim places Type J and L claims on hold status until the Type A recoupment is completed. ARTS automatically resumes recoupment of the Type J or L claim when all of the individual's Type A

claims have been paid in full.

B—761.1.3 Recoupment Amount

Revision 15-4; Effective October 1, 2015

TANF

HHSC recoups Type A, J, and L claims at 10 percent of the household's maximum grant, rounded down to the nearest dollar.

Once a TANF claim is recouped in full, TIERS will automatically rebudget any active SNAP EDG to include the appropriate ongoing TANF grant amount. See A-1324.18, Temporary Assistance for Needy Families (TANF).

SNAP

For Type A claims, HHSC recoups at 20 percent of the household allotment or $20, whichever is greater. When calculating a dollar amount using the percentage, TIERS rounds 49 cents down and 50 cents up to the next whole dollar.

For Types J and L claims, HHSC recoups at 10 percent of the household allotment or $10, whichever is greater. When calculating a dollar amount using the percentage, TIERS rounds 49 cents down and 50 cents up to the next whole dollar.

Notes:

- When benefits are $10 or less, no benefits are issued.
- When a current household member is disqualified for an IPV, recoupment is computed using the allotment the household would receive if the disqualified member was included in the household size.

B—761.2 Restitution

Revision 19-3; Effective July 1, 2019

TANF and SNAP

Restitution is a method of recovering an overpayment claim by receiving payments in the form of a cashier's check, certified or personal check, money orders made payable to the Texas Health and Human Services Commission, or credit or debit card payments through the Texas.gov HHSC Online Overpayment System (HOOPS).

B—761.2.1 Action on Restitution Cases

Revision 20-2; Effective April 1, 2020

TANF and SNAP

When OIG establishes an overpayment claim, Form OIG 5027, Repayment Agreement is sent to the primary liable household member along with Form OIG 5034, Notice of SNAP Overpayment Claim, or Form OIG 5039, Notice of TANF Overpayment Claim.

The primary liable household member has 30 days from the date on the repayment agreement to agree to restitution by signing the agreement and returning it to the OIG investigator. The repayment agreement provides the household with both the signature and first payment due date.

OIG staff are responsible for sending the repayment agreement, signed or unsigned, to HHSC Accounts Receivable for processing as soon as it is received. For the household to avoid delinquency, all payments must be sent to HHSC Accounts Receivable on or before the 30th day from the date on the repayment agreement.

If a household has delinquent restitution payments and TIERS is unable to match an overpayment claim to a liable household member currently receiving benefits, then the overpayment claim is eligible for referral to the:

- Federal Treasury Offset Program (TOP) for an intercept of federal payments (only applicable to SNAP claims once the payment is 120 days delinquent);
- Texas Comptroller of Public Accounts for interception of any state payments, including lottery winnings; or
- appropriate agencies to request suspension of licenses.

Restitution payments cannot be made in lieu of mandatory recoupment. If a liable household member is making restitution payments and becomes certified on an active case, then the liable household member is switched from a restitution payment plan to a recoupment payment plan. Recoupment begins after the first month of certification. Once ARTS receives notification from TIERS of the first recoupment payment from the active case, ARTS automatically switches the payment plan from restitution to recoupment.

If the household was on a restitution payment plan and receiving bills, all billing will stop until the household stops receiving benefits or when the claim is paid in full.

In order to pay down their overpayment balance, households may make extra restitution payments in addition to their mandatory repayment or recoupment payments.

Related Policy

Identifying Liable Members, B-753.1
Action on Recoupment Cases, B-761.1.1
Restitution Amount, B-761.2.2

B—761.2.2 Restitution Amount

Revision 19-3; Effective July 1, 2019

TANF and SNAP

The repayment agreement reflects a 36-month amortized schedule for the claim to be repaid within three years. If the amortized monthly payment is less than $25, then the agreement is generated with $25 as the minimum payment.

Only HHSC Accounts Receivable staff can renegotiate a payment plan differing from the one on the repayment agreement. Accounts receivable staff sends all subsequent monthly bills or repayment agreements to households after OIG sends the initial repayment agreement.

B—762 Action on Receipt of Payments

Revision 19-3; Effective July 1, 2019

TANF and SNAP

When staff receive restitution payments, staff:

- complete Form H4100, Money Receipt; and
- submit the payment or warrants with a copy of Form H4100 within 24 hours of receipt to:

  Texas Health and Human Services Commission
  Accounts Receivable
  P.O. Box 149055
  Austin, TX 78714-9055

Note: Staff must mark each TANF warrant void when received.

B—763 Debit of SNAP EBT Accounts

Revision 13-3; Effective July 1, 2013

SNAP

Debit of an EBT food account is a method of recovering an overpayment claim by electronically removing benefits from the household's EBT account. The value of the debit is applied to the SNAP claim.

B—763.1 One-Time Debit of an Active EBT Account

Revision 20-2; Effective April 1, 2020

SNAP

A household member liable for an overpayment with an active EBT food account may request a one-time debit of the EBT food account as payment toward a SNAP overpayment claim instead of making separate recoupment payments. When this occurs OIG or HHSC Accounts Receivable staff:

- use the EBT System to verify the:
  - status of the EBT food account; and
  - balance of the account;

- complete Form H1021, Payment Agreement — Verbal Authorization for One-Time Debit of an Active Lone Star Food Account to document the verbal authorization to repay the claim by removing benefits from the active EBT food account;
- inform the liable household member:
  - that the amount of the one-time payment must be maintained in the EBT account until the debit is completed; and
  - that it takes approximately 14 days for the debit transaction to be completed.
  - the person will receive a receipt of the debit within 10 days of the debit transaction; and
- submit the original of Form H1021 by:
  - Mail:
    HHSC Lone Star Business Services
    State Office
    Mail Code 2033; or
  - Fax: 512-206-5961; and
- Maintain a copy of Form H1021 in the OIG or ARTS file.

Lone Star Business Services staff remove the SNAP benefits from the food account and submit Form H1021 to Accounts Receivable to pay the claim.

Note: When the liable household member contacts HHSC and disagrees with the debit transaction, they may request a fair hearing to request the return of the benefits to their account.

Related Policy

Identifying Liable Members, B-753.1
Fair Hearings, B-764

B—763.2 Offset Expunged Benefits

Revision 19-3; Effective July 1, 2019

SNAP

When staff become aware that a household has expunged SNAP benefits, OIG or HHSC Accounts Receivable staff must offset the balance of a SNAP claim by the amount of the expungement.

B—764 Fair Hearings

Revision 20-4; Effective October 1, 2020

TANF and SNAP

When it is unclear whether the household wishes to appeal an action taken by eligibility staff or an action taken by OIG staff, eligibility staff and OIG review the request for an appeal to determine what action the household is appealing. If a household disputes the establishment of a claim or collection action initiated by OIG and requests an appeal, OIG will take the lead and begin processing the appeal. Eligibility staff must attend the hearing along with OIG if the appeal includes the eligibility staff's action that was not part of the establishment of the claim.

Note: Form H4800, Fair Hearing Request Summary, is not used to submit an appeal request when the household disputes the establishment of a claim or action initiated by OIG. If Form H4800 is sent directly to the hearings division, it will be returned to staff with instructions to correctly submit the information.

OIG Staff

OIG staff use the Automated System for the Office of Inspector General (ASOIG) to submit appeal requests on claims or collection actions.

OIG staff use the State Portal Appeals tab and the Hearing Evidence Packets Upload tab to send evidence documents related to an appeal request.

Exception: When ASOIG is not available or an investigation is not found in ASOIG, OIG staff process the appeal through the TIERS Hearings and Appeal function located in the left navigation menu.

Eligibility Staff Working in TIERS

When a person verbally requests an appeal, process the fair hearing request by selecting the Hearing and Appeal option found on the left-navigation menu in TIERS and choose Create Appeal.

When a fair hearing request is received in writing by fax or mail, fax the appeal request, using the fair hearing cover sheet, through the expedited fax line (866-559-9628) for processing. The fair hearing request is not entered in the State Portal.

Whether the TIERS appeal request is received verbally or in writing, the Centralized Representation Unit (CRU) continues to process the appeal, including creating and submitting the evidence packet. Copies of the evidence packet are mailed to the appellant and any authorized or legal representative.

Related Policy

Appeal Procedures, B-1030
Local Office Procedures for Hearing Requests, B-1031
Providing Form H4800-A, Fair Hearing Request Summary (Addendum), to Hearings Division, B-1031.2

B-770, Filing an Overpayment Referral

Body

Revision 12-2; Effective April 1, 2012

B—771 Filing an Overpayment Referral Using Automated System for the Office of Inspector General (ASOIG)

Revision 15-4; Effective October 1, 2015

All Programs

Staff create referrals for overpayments caused by agency error, individual error/misunderstanding, or suspected IPV or fraud in ASOIG.

ASOIG is accessed at the following website: https://hhsportal.hhs.state.tx.us/asoig.

Users log in using a unique sign on. A disclaimer page explaining IRS Federal Tax Information requirements must be agreed to before proceeding with the referral. Agreement takes the user to the ASOIG home page.

Investigation is selected from the left navigation menu to proceed to the Referral and Investigation search page. Users must enter identifying information and select Create Referral.

Identifying information may consist of one or more of the following:

- Suspect name,
- Individual (client) number,
- Social Security number, or
- EDG or case number.

The Create Referral tab takes the user to the Create Referral screen group. This consists of the **Referral, Suspects, Reasons, Contacts, Comments** and **Assignment** tabs. The user must go through all tabs, enter information as appropriate, and save the referral.

The **Referral** tab is the first tab in creating a referral. The tab has two areas. The top part, Alleged Information, is for entering biographical information. The bottom portion, EDG Types, is used to enter whatever program type information is known.

The New button at the bottom of the tab is used when adding types to the EDG Types portion of the tab. If the referral is associated with more than one EDG, users must click the New button to add additional types. The user must continue to click the New button until all EDGs associated with the referral are added. Once all types have been entered, the user must click the Next button to proceed to the next tab, **Suspects**.

The **Suspects** tab is used to enter information on suspects as well as household members associated with the referral. The top portion of the screen, Suspect, allows for the entry of any known biographical information. The bottom portion, Address, is for entering any known address(es).

At least one suspect screen with a name and type of suspect is required for a referral. Although children are not "suspects," entering all household members is recommended as that information will be required if an investigation is merited.

If an automated interface finds information in TIERS, users may select from a list of names. If a name is chosen from the list in this field, the ASOIG populates applicable biographical and EDG information such as date of birth, Social Security number and address. If TIERS information is not found, users must enter all known information.

The New button on the tab is to allow the user to include all household members in the referral. Once all members are entered, the user must click the Next button to advance to the next tab, **Reasons**.

The **Reasons** tab is used to establish the basis for the referral. The screen is divided into three sections, Reason, Source Information and Source Detail. One reason type and name is required for each referral.

Multiple reasons may be entered on a single referral. If there are multiple reasons, users enter the information for the first reason and then click the New button to enter information for the next reason. Once all applicable reasons are entered, the user must click the Next button to move to the next tab, **Contacts**.

The **Contacts** tab is used to enter sources of information such as another employee, agency or other person with information about the referral. The screen is divided into two sections. The Contact portion is for information on the source of information while the Address portion is for documenting any address information for the contact.

A **Contacts** entry is not required for a referral, but multiple entries may be made by clicking the New button. Clicking on the Next button takes the user to the next tab, **Comments**.

The **Comments** tab is used to enter information on the referral. It is used to document information not otherwise captured by ASOIG. At least one comment is required and multiple comments may be entered. Comments are listed by subject, and users should enter a concise statement in the subject to describe the contents of the comment.

Comments may be linked to a **Contact** by clicking the Related Contact checkbox.

Once a comment is saved by clicking the New or Next button, it cannot be modified. Care must be exercised in completing this tab. Clicking the Next button takes the user to the final tab, **Assignment**.

The **Assignment** tab allows the assignment of the referral based on predefined rules. Once the Save Referral button is clicked, the referral is saved and all information is locked, except for the ability of the user to include additional comments.

Saving the referral takes the user back to the **Referral** tab; however, it is only for viewing, and the user now has the ability to attach any electronic documents saved on the user's computer to the referral. Attach documents by clicking the paper clip icon next to the tabs, browse to select the document, give a name to the document, describe the contents of the document and click Save. Multiple documents may be attached using the New button.

Note: Logging out of the referral before it is saved on the **Assignment** tab will result in loss of information entered, requiring the user to start over.

B—772 Filing an Overpayment Referral Using TIERS

Revision 15-4; Effective October 1, 2015

SNAP and TANF

When eligibility staff discover that an overpayment exists, either by advisor knowledge or because it is identified in the TIERS Eligibility Summary, the following steps must be taken to enter the referral in TIERS:

- From the left navigation menu, the user must go to Data Collection > Initiate Interview and enter the case number and case mode. If a case is already in ongoing mode, the user may enter the referral.
- From the left navigation menu, the user must select Data Collection > Miscellaneous > Referral. The TIERS referral summary page will display. If an overpayment claim exists for the EDG, there will be an entry for the advisor to review on this page. To review the claim, the user must click on the edit icon.
- To enter a new referral, the user must click the red Add button.
- On the Details page, the user must enter the following information:
  - Name – From the drop-down menu, select the name of the individual causing the overpayment.
  - Effective Begin Date – Enter the date the overpayment began.
  - Discovery Code – From the drop-down menu, select the most appropriate entry to describe how the overpayment was discovered. If no entry is appropriate, select "other."
  - Error Referral Type – From the drop-down menu, select an entry based on the entity causing the error. For errors caused by the agency's error or failure to take action in a timely manner, select "agency." For errors caused by individuals without the intent to commit fraud, select "client." For errors where eligibility staff believe the individual intentionally committed fraud to receive additional benefits, select "fraud."
  - Overpayment Reason – From the drop-down menu, select the most appropriate reason for the overpayment. If no entry is appropriate, select "other."
  - Overpayment Discovery Date – Enter the date HHSC discovered the overpayment.
  - Benefit Type – From the drop-down menu, make the appropriate selection based on the type of benefit overpaid.
  - Financial Penalty Code – For overpayments caused by TANF Personal Responsibility Agreement (PRA) noncompliance, select the area with which the individual noncomplied.
  - Destination Unit – Select the appropriate unit by region and by the type of referral (CI – Claims Investigation/FI – Fraud Investigation).
  - Referral Benefit Restored Amount – If the overpayment was caused by the issuance of restored benefits, enter the overpayment amount in this field. If the overpayment was not caused by the issuance of restored benefits, a zero entry remains in this field.
  - Form 1898 Completion Date – This field is used for overpayment claims caused by the issuance of restored benefits only. Enter the date Form 1898, Restored Benefits Documentation, was completed at the time the restored benefits were authorized.
  - First Month and Year of Overpayment – Enter the month and year the overpayment began. Estimate only.

    - Last Month and Year of Overpayment – Enter the month and year the overpayment ended. Estimate only.
    - Overpayment Amount – Enter the dollar amount of the overpayment for all referrals except referrals based on restored benefits. If the overpayment was caused by the issuance of restored benefits, this field should contain a zero entry. Estimate only.
    - EDG Participation – For the individual causing the overpayment, select whether or not the individual was a member of the certified group.
    - Participation Change Date – For claims based on household changes, enter the date the participation status changed for the individual causing the overpayment.
    - Participation Change Report Date – For claims based on household changes, enter the date HHSC learned of the household change.
    - Enter comments you wish OIG to receive by entering page-level comments on this page – Click on the center icon next to the **Referral – Details** title to enter page-level comments.
- On the Income page (for overpayments caused by income only), if known, the user enters the following information:
    - Source Type – From the drop-down menu, select "earned income" or "unearned income" depending on the type of income causing the overpayment.
    - Source Name – Enter the name of the entity that provided the income that caused the overpayment. This may be the name of an individual, company or government agency.
    - Verification Source – From the drop-down menu, make the appropriate verification source selection. If the source used to verify the income is not available on the menu, select "none" and document the source in page-level comments on the details tab.
    - Source Hire Date – For earned income overpayments, enter the hire date for the individual.
    - First Check Date – Enter the date the individual received the first payment that caused the overpayment. **Note:** This could be a check or cash payment, and the payment could be for earned and unearned income.
    - Source Report Date – Enter the date the individual informed HHSC of the income change.
    - Source Amount – Type the monthly amount of the income received from the source.
    - Income Source Address – If known, enter the address of the income source.
- On the Resources page (for overpayments caused by resources only), if known, the user enters the following information:
    - Resource Type – From the drop-down menu, select the most appropriate entry for the type of resource causing the overpayment. If no selection is appropriate, select "other."
    - Resource Change Date – Enter the date the individual obtained possession of the resource.
    - Resource Report Date – Enter the date HHSC learned of the resource change.
    - Resource Amount – Enter the countable value of the resource.
- The user must document the overpayment referral and reason in TIERS Case Comments.

B-780, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Advisors must document in TIERS Case Comments:

- that an overpayment referral was made via ASOIG or through the TIERS interface, according to B-730, How to File an Overpayment Referral; and
- a brief description of the overpayment, and how and when the overpayment was discovered, according to B-711, Types of Overpayment Claims.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

B-800, Restored Benefits

B-810, Entitlement to Restored Benefits

Body

Revision 10-2; Effective April 1, 2010

TANF and SNAP

Households are entitled to restored benefits when:

- legislation, federal regulations or court actions require restoration;

- the Health and Human Services Commission (HHSC) makes an error in the household's amount of benefits and the household was not at fault;
- an individual is disqualified for an intentional program violation, which is later reversed by a court; or
- the Supplemental Nutrition Assistance Program (SNAP) or an authorized representative of a drug and alcohol facility improperly accesses and fails to return the benefits to the individual's EBT account.

Households are **not** entitled to restored benefits for unreported changes or household errors.

Households are entitled to restored benefits regardless of whether they are currently eligible for or receiving benefits.

B-820, Time Frames for Qualifying for Restored Benefits

Body

Revision 10-2; Effective April 1, 2010

TANF and SNAP

Restore benefits as directed by a court or if the loss occurred within 12 months of the date:

- the household:
  - contests an adverse decision,
  - attends a disqualification hearing, or
  - notifies HHSC that it believes it has lost benefits.
- HHSC discovers that the household may be entitled to a restoration.

The month the agency discovers the household is entitled to a restoration is counted as month zero.

B-830, How to Determine the Amount of Restored Benefits

Body

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Texas Integrated Eligibility Redesign System (TIERS) Eligibility performs the steps to calculate restored benefits in most instances. The advisor may be required to manually calculate the restored benefit, record the restored benefit and offset information, and issue benefits using the Benefit Issuance – Manual Issuance functional area in TIERS.

1. Determine the month the loss began.
2. Exclude months before the 12-month time limit.
3. Determine if the household was eligible for each month the household lost benefits.
4. Obtain needed information to determine eligibility for any restored benefit month in question.
5. For each month, compute the amount of benefits the household should have received.
6. Determine the restored benefit amount by subtracting the correct benefits from the amount of benefits actually issued. If there is a claim, subtract the restored benefit amount from the amount due on the claim. Issue any remainder to the household.

Note: When initial benefits are paid retroactively, do not reduce the retroactive payment to offset previous claims.

Issue restored benefit(s) within 30 days of the date the agency discovers the underpayment.

B—831 Procedures for Counting Restored Benefits Toward a Claim

Revision 13-3; Effective July 1, 2013

TANF and SNAP

1. Document the amount of restored benefits owed on the Restored Benefits Details page or Request Manual Issuance page.
2. Determine if there is a claim, as noted in A-832, How to Verify a Claim Amount. Refer to B-761.1.1, Action on Recoupment Cases.
3. The nightly interface between TIERS and the Accounts Receivable Tracking System (ARTS) will report the offset.
4. Notify the individual on Form H1825, Entitlement to Restored Benefits.

B—832 How to Verify a Claim Amount

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Advisors must go to Benefits Issuance on the left navigation bar and click on View Overpayments to verify a claim amount. TIERS users can search for overpayment information by entering a Social Security number, an Eligibility Determination Group (EDG) number or claim number. The Search Results display columns are: Social Security number, EDG number, EDG Name, Claim number and Individual number. Clicking on the Social Security number hyperlink will display overpayment information, which includes the remaining overpayment balance.

B-840, Notice to the Household

Body

Revision 01-3; Effective April 1, 2001

TANF and SNAP

Notify the household by Form H1825, Entitlement to Restored Benefits, of

- their entitlement to restored benefits,
- the amount and method of restoration,
- any claim offset, and
- the right to appeal.

B-850, Disputed Benefits

Body

Revision 13-3; Effective July 1, 2013

TANF and SNAP

If the household disagrees with the amount of restored benefits, or any other action the advisor takes to restore them, the household may request a hearing within 90 days of the notice date. The advisor continues the restoration while waiting for the hearing decision and adjusts the benefits according to the hearing officer's decision.

The household may request a hearing if the household believes it is entitled to restored benefits but the advisor does not agree. Document on the appropriate worksheet the request for restored benefits, the justification to deny them, and the date.

B-860, Method of Restoration

Body

Revision 13-3; Effective July 1, 2013

TANF

Restore all benefits owed to the household at the same time. Issue a separate benefit for each month the household is owed benefits.

SNAP

Restore all benefits owed the household at the same time.

Issue a separate EBT benefit for each month the household is owed restored benefits.

B-870, Changes in Household Composition

Body

Revision 01-3; Effective April 1, 2001

TANF and SNAP

If household membership changes, issue restored benefits to the household containing a majority of the persons who were household members when the loss occurred.

If the worker cannot locate an individual or determine which household contains a majority of members, restore benefits to the household that includes the person who was the head of the household when the loss occurred.

B-880, Procedure for Authorizing Restored Benefits

Body

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Authorize the restoration within 30 days of the date the agency discovers the underpayment.

A Second Level Review (SLR) is required when, in TIERS Eligibility:

- Restored benefits are being issued for more than three months prior to the current date.
- The total restored benefit amount (prior to offset) for TANF is equal to or greater than $50.
- The total restored benefit amount (prior to offset) for SNAP is equal to or greater than $125.

An SLR is required for all restored benefits requested in Manual Issuance.

B-890, Documentation Requirements

Body

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Advisors are required to document

- why the household is entitled to restored benefits;
- the month the loss of benefits began;
- the time frames for benefits owed;
- computations;
- if there is a claim against the household; and
- the amount of restoration approved if the household has an offset.

Note: The documentation requirements will be met if appropriate entries are made on the Restored Benefits Details page or Request Manual Issuance page.

Document in the case record the:

- request for restored benefits;
- justification to deny the request; and
- date according to B-850, Disputed Benefits.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

B-900, Referrals for Intentional Program Violation

B-910, General Policy

Body

Revision 15-4; Effective October 1, 2015

All Programs

An IPV occurs when a person intentionally makes a false or misleading statement, or misrepresents, conceals, or withholds facts for the purpose of receiving assistance under Texas Health and Human Services Commission (HHSC) benefit programs.

Note: A person may be charged with an IPV, even if benefits the person was not entitled to receive have not actually been received.

SNAP

An IPV occurs when a person commits an act that constitutes a violation of the Food and Nutrition Act, the Supplemental Nutrition Assistance Program (SNAP) regulations, or any state statute for the purpose of using, presenting, transferring, acquiring, receiving, possessing, or trafficking of benefits, authorization cards, or reusable documents used as part of an electronic benefit delivery system (Electronic Benefit Transfer [EBT]).

B—911 Elements of an IPV

Revision 11-4; Effective October 1, 2011

All Programs

An IPV must contain at least one or more of the following elements:

- a falsified document,
- a falsified statement,
- a falsified interview,
- a continuing scheme, or
- trafficking of benefits.

See Glossary for definitions of the above terms.

B—912 IPV Disqualification Penalties

Revision 20-4; Effective October 1, 2020

General Policy

The Office of Inspector General (OIG) may establish an overpayment claim for a person found guilty of committing fraud in the SNAP and TANF programs. There is no IPV disqualification or disqualification penalty imposed for Medicaid or the Children's Health Insurance Program (CHIP).

SNAP and TANF

A person found guilty of an IPV by a court will be disqualified as specified by the court. If the court fails to specify a disqualification, OIG will impose the appropriate IPV disqualification penalty as listed below.

TANF

A person found guilty of an IPV by an administrative disqualification hearing (ADH) or who signs an ADH waiver for an IPV that occurred on or after Sept. 1, 2003, will be disqualified:

- for 12 months for the first offense; and
- permanently for the second offense.

A person convicted of a state or federal IPV and granted deferred adjudication, or placed on community supervision for conduct that constitutes an IPV, will be permanently disqualified from receiving TANF assistance.

Exception: A person found guilty of an IPV in federal court, state court, or in an ADH for making a fraudulent statement or representation with respect to the identity or residence of the person to receive multiple benefits simultaneously, will be disqualified for 10 years.

SNAP

A person found to have committed an IPV either through an ADH or by a federal, state, or local court, or to have signed either a waiver of right to an ADH or a disqualification consent agreement in cases referred for prosecution, will be disqualified:

- for 12 months for the first offense;
- for 24 months for the second offense; and
- permanently for the third offense.

SNAP Specified Offenses

A person found guilty of an IPV in a federal court, state court or in an ADH for making a fraudulent statement or representation with respect to the identity or residence of the person to receive multiple benefits simultaneously, will be disqualified for 10 years.

A person found guilty of an IPV in federal, state, or local court of having used or received SNAP benefits in a transaction involving the sale of a controlled substance will be disqualified:

- for 24 months for the first occasion; and
- permanently for the second occasion.

A person convicted by a federal, state or local court of an IPV due to trafficking in SNAP benefits or program access devices, such as EBT cards, with a conviction for an aggregate amount of $500 or more, will be permanently disqualified.

A person found guilty of an IPV in federal, state, or local court of having used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives will be permanently disqualified.

B-920, When to File an IPV Referral

Body

Revision 15-4; Effective October 1, 2015

All Programs

Staff are responsible for reporting to OIG any acts of fraud, waste, abuse, or misconduct in the following HHSC benefit programs:

- Temporary Assistance for Needy Families (TANF),
- SNAP,
- Medicaid, and
- CHIP.

B-930, How to File an IPV Referral

Body

Revision 15-4; Effective October 1, 2015

All Programs

Staff submit a fraud or IPV referral using either the:

- Automated System for Office of Inspector General (ASOIG), or
- Texas Integrated Eligibility Redesign System (TIERS) referral interface.

Note: If the fraud allegation contains confidential information and/or the person making the allegation requests to remain anonymous, the referral is submitted using ASOIG. Any supporting information and/or evidence should be attached to the referral using ASOIG. The TIERS referral interface does not allow attachments.

Staff must follow instructions in B-770, Filing an Overpayment Referral, for submitting a referral using either ASOIG or the TIERS referral interface.

B-940, Texas Works Responsibilities

Body

Revision 26-2; Effective April 1, 2026

All Programs

Identify potential fraud or intentional program violations (IPVs).

Submit fraud or IPV referrals to the Office of the Inspector General (OIG). Use the Automated System for the Office of Inspector General (ASOIG) or the Eligibility System referral interface, within 30 days of the date the IPV is identified.

Process fair hearing requests about claims or collections after instructions for appeals for the Accounts Receivable Tracking System (ARTS), in the Eligibility System.

Forward any payments received in the local office to:

Texas Health and Human Services Commission
Fiscal Management Services
ARTS Billing
P.O. Box 149055
Austin, TX 78714-9055

Refer any questions about collections on established claims to Fiscal Management Services (FMS).

Note: The FMS hotline number is 800-666-8531. ARTS is administered by FMS staff who monitor and process payments from HHSC claims.

Report fraud or violations of SNAP rules by drug and alcohol treatment (D&A) and group living arrangement (GLA) facilities. Do this by emailing Form H1095, Treatment Facility Fraud Referral, Form H1096, Notification Letter, and if applicable, Form H1853, Documentation of Findings for Form H1852, to HHSC OIG Benefits Program Integrity (BPI).

Report retail stores to Lone Star Business Services by email to HHSC Lone Star who:

- allow unauthorized purchases; and
- accept benefits for previous purchases.

Related Policy

Appeals Related to Accounts Receivable Tracking System (ARTS), B-1035

B-941 Disqualifying a Household Member with a Current SNAP Out-of-State IPV Disqualification

Revision 22-3; Effective July 1, 2022

SNAP

When out-of-state SNAP IPV disqualification data from the SNAP federal Electronic Disqualified Recipient System (eDRS) is identified on Data Broker, discuss the IPV with the member to determine whether the member agrees with or disputes the information. Complete as much of the application process as possible and dispose the application for other programs, if applicable. Follow the procedures below for SNAP.

Exception: This policy does not impact SNAP Combined Application Project (SNAP-CAP) Eligibility Determination Groups (EDGs) administered by Centralized Benefit Services (CBS), with one exception in SNAP-CAP circumstances related to Intentional Program Violations (IPVs) and Felony Drug Convictions.

Procedures When Data Broker Identifies an eDRS Match

If the situation is ...	then ...
A. an expedited SNAP application, and the household does not dispute the IPV data,	• complete Form H1856, SNAP Out-of-State Intentional Program Violations, indicating it is for an expedited application; • send a copy for imaging; • email the form to Customer Care Center (CCC)-eDRS eligibility staff at HHSC OES CCC IC, indicating Expedited in the email subject line; and • document this action in case comments. CCC-eDRS staff will review the form for accuracy and immediately email it to OIG-Central Disqualification Unit (CDU). If the email is received by 4:30 p.m. Central Standard Time, OIG -CDU staff take action the same day. They enter the IPV disqualification data from Form H1856 into TIERS, create a reported change task to notify staff to complete and dispose the SNAP EDG, and email staff

If the situation is ...	then ...
	notice of the change. **Exception**: Out-of-state IPVs with non-standard penalty periods are noted on Data Broker and require secondary verification as described in Box D.
	• postpone verification of the IPV penalty and certify the application without the penalty; • complete Form H1856, indicating it is for an expedited application; • send a copy for imaging; • email Form H1856 to CCC-eDRS eligibility staff at HHSC OES CCC IC to obtain secondary verification of the out-of-state IPV data; and • document this action in case comments.
B. an expedited SNAP application, and the household disputes the IPV disqualification,	If the out-of-state IPV verification is: • received by the final due date, CCC-eDRS staff forward Form H1856 to OIG, who will enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify the local office staff to complete and dispose the SNAP EDG. • not received by the final due date, the local office staff must dispose the application without imposing the IPV disqualification. When the secondary verification is received, CCC-eDRS staff forward Form H1856 to OIG-CDU staff at HHSC CDU. OIG-CDU staff enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify CCC to dispose the penalty as a change and create an overpayment claim referral back to OIG.
	Staff must discuss the out-of-state IPV disqualification with the household to confirm the IPV data if possible. If the household does not dispute the IPV data: • complete Form H1856; • send a copy for imaging; • email Form H1856 to CCC-eDRS eligibility staff at HHSC OES CCC IC; and • document this action in case comments. CCC-eDRS staff review the form for accuracy and immediately forward it to OIG-CDU at HHSC CDU. OIG-CDU staff enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify staff to complete and dispose the EDG. Exception: Out-of-state IPVs with non-standard penalty periods are noted on Data Broker and require secondary verification as described in Box D.
C. a SNAP non-expedited application, household addition or redetermination,	If not possible to contact the household or the household disputes the IPV, then: • manually pend the SNAP EDG action until the final due date for CCC-eDRS staff to complete secondary verification; • complete Form H1856; • send a copy for imaging; • email Form H1856 to CCC-eDRS staff at HHSC OES CCC IC for a secondary verification as described above; and • document this action in case comments. If the secondary verification is not received and OIG has not entered the IPV disqualification by the: • final due date on an application or redetermination, process it without imposing the IPV disqualification. • 20th day after sending Form H1856 on a requested household addition, process the change without imposing the IPV disqualification. When CCC-eDRS staff subsequently receive the out-of-state IPV verification, staff forward it to OIG. OIG-CDU staff will enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify staff to dispose the EDG and create an overpayment claim referral back to OIG.
D. the IPV data on a Data Broker report is marked as “non-standard” (i.e., the penalty period listed is not a standard length),	• manually pend the SNAP EDG action until the final due date for CCC-eDRS staff to complete secondary verification; • complete Form H1856;

If the situation is ...	then ...
	• send a copy for imaging; • email Form H1856 to CCC-eDRS eligibility staff at HHSC OES CCC IC to obtain secondary verification of the IPV before imposing the disqualification in Texas; and • document this action in case comments. **Note:** Postpone verification if expedited. If not expedited, process the application as explained in Box C.

Note: If the person is not active on a SNAP EDG or the application has already been denied, OIG will enter this out-of-state IPV data into TIERS since the person is known to TIERS. No staff action is required in this situation.

Related Policy

Identifying Intentional Program Violations (IPVs) and Felony Drug Convictions, B-475.2.1

B-942 Disqualifying a Household Member with a Current TANF Out-of-State IPV Disqualification

Revision 15-4; Effective October 1, 2015

TANF

When the advisor discovers that an individual has an out-of-state TANF IPV disqualification, the advisor must discuss the IPV with the individual to determine whether the individual disputes the information.

If the household does not dispute the IPV data …	the advisor must …
	• complete as much of the application process as possible and dispose the application for other programs if applicable, • pend the TANF EDG until OIG notifies the advisor to complete and dispose the EDG, and • send a secure email referral to OIG-CDU staff at CDU@hhsc.state.tx.us containing the following information: Subject: TANF Out-of-State IPV Out-of-state IPV information: ◦ TANF EDG number ◦ Originating state where IPV occurred ◦ Disqualified individual's: ▪ Name ▪ Social Security number (SSN) ▪ Date of birth (DOB) ◦ Client number in originating state ◦ Number of disqualified months ◦ Disqualified begin date ◦ Disqualified end date ◦ Offense occurrence ◦ Offense description ◦ Federal or state court or administrative hearing decision date Document the IPV information and the email sent to OIG in TIERS Case Comments. OIG-CDU staff will enter the IPV disqualification data from the email into TIERS and create a reported change task to notify the advisor to complete and dispose the EDG.
If unable to contact the household or the household disputes the IPV data …	the advisor must …

If the household does not dispute the IPV data …	the advisor must …
	• complete as much of the application process as possible and dispose the application for other programs if applicable, • pend the TANF EDG until OIG notifies the advisor to complete and dispose the EDG*, and • send a secure email referral to CCC-eDRS staff at HHSC OES CCC IC containing the following information: Subject: TANF Out-of-State IPV – Pending Secondary Verification Out-of-state IPV information: ◦ TANF EDG number ◦ Originating state where IPV occurred ◦ Disqualified individual's: ▪ Name ▪ SSN ▪ DOB ◦ Client number in originating state ◦ Number of disqualified months ◦ Disqualified begin date ◦ Disqualified end date ◦ Offense occurrence ◦ Offense description ◦ Federal or state court or administrative hearing decision date ◦ Whether the individual was/wasn't contacted ◦ If the individual disputes the IPV, details regarding why the claim is disputed Document the IPV information and the email sent to CCC-eDRS in TIERS Case Comments. CCC-eDRS staff will obtain secondary verification of the IPV and immediately forward the secondary verification to OIG. OIG will enter the IPV information into TIERS. * If OIG has not entered the IPV disqualification by the final due date, process the application or redetermination without imposing the IPV disqualification.

B-943 Expiration of an IPV Disqualification Penalty

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Once the IPV disqualification penalty begins, it continues even when benefits expire or the EDG is denied. If the person reapplies for benefits, advisors must ensure that the person has served the IPV disqualification penalty before certifying the person for benefits.

Example: A person reapplies for TANF and SNAP on April 4, 2011, for herself and her three children.

The advisor checks the person's IPV disqualification status by viewing the person's Individual-Summary using the hover menu IPV Sanctions page. The person was found guilty of committing an IPV offense on February 4, 2011, resulting in a 12-month SNAP IPV disqualification beginning March 1, 2011, through February 28, 2012. Since the disqualification period has not expired, the advisor must continue the person's disqualification.

Notes:

- Form OIG5042, Notice of Disqualification Enforcement, may be viewed under Case Data Search.
- To determine eligibility for the remaining household members, advisors use the budgeting procedures in:
  - A-1362.2, TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction; and
  - A-1362.4, SNAP — Budgeting for Persons Disqualified for Intentional Program Violations, SNAP Employment Services Noncompliances, Felony Drug Convictions or Being a Fugitive.

B—944 Reinstatement of an IPV Disqualified Person

Revision 14-1; Effective January 1, 2014

TANF and SNAP

When the IPV disqualification penalty period expires on an active EDG, TIERS automatically adds the formerly IPV disqualified person to the household and adjusts benefits accordingly.

B—945 Request for New Administrative Disqualification Hearing (ADH)

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When a person disqualified for an IPV contacts the local office and claims that the individual did not receive an ADH notice and requests a new hearing, staff must notify the Office of Social Services (OSS) – Eligibility Services Support (ESS) Centralized Representation Unit (CRU). CRU coordinates with OIG in processing new ADH requests.

Staff provide CRU the following information:

- person's name,
- EDG number,
- date of disqualification, and
- status of the person's EDG (active, denied, pending).

Note: If the ADH officer grants a person's request for a new hearing, the CDU:

- removes the IPV disqualification, and
- contacts Texas Works to re-run the budget to allow for the person’s continued benefits pending the new ADH.

B-950, OIG Responsibilities

Body

Revision 20-4; Effective October 1, 2020

All Programs

OIG Benefits Program Integrity (BPI) is organized as follows:

- Research Analysis and Policy Training (RAPT) unit;
- Central Disqualification Unit (CDU);
- Claims Investigations (CI) units; and
- Field Investigations (FI) units.

The EBT Trafficking unit is also part of the OIG Investigations division and works closely with BPI.

OIG staff:

- review allegations of HHSC benefit program recipient fraud, including employee, recipient or retailer EBT trafficking fraud;
- investigate allegations of recipient or employee fraud to determine whether fraud exists and, if applicable, the amount of an overpayment;
- establish fraud claims through the Fiscal Management Services Accounts Receivable Tracking System (ARTS);
- coordinate with the HHSC Fair and Fraud Hearings Division for investigations submitted for ADH;
- coordinate with the local district attorney office for investigations submitted for prosecution;
- coordinate with U.S. Department of Agriculture (USDA) EBT trafficking investigations;
- dispose investigations based on the results of either prosecution or ADH;
- impose an IPV disqualification penalty, if applicable; and
- coordinate with the HHSC-OSS – Eligibility Operations Customer Care Center (CCC) to adjust active HHSC program benefit amounts, if appropriate.

B—951 Facts Do Not Support an IPV

Revision 15-4; Effective October 1, 2015

All Programs

The facts do not support an IPV when:

- OIG staff review and determine that the facts do not support the allegation,
- a court determines the person is not guilty, or
- an ADH hearing officer determines that no IPV was committed.

OIG staff may process these claims as inadvertent household errors/misunderstandings.

B—952 Facts Support an IPV

Revision 15-4; Effective October 1, 2015

All Programs

When OIG determines that the facts support an IPV allegation, OIG submits the case to either the:

- local district attorney for prosecution, or
- Fair and Fraud Hearings Division for an ADH.

Note: A person may waive the right to an ADH by signing Form OIG5040, which allows OIG to establish a fraud claim and impose an IPV disqualification.

B—953 Enforcement of IPV Disqualification

Revision 15-4; Effective October 1, 2015

TANF and SNAP

OIG-CDU staff enforce the IPV Disqualification and associated disqualification penalty.

B—953.1 Notice of an IPV Disqualification

Revision 15-4; Effective October 1, 2015

TANF and SNAP

CDU staff receive the following notices that a household member has been disqualified due to an IPV:

- Form H1856, SNAP Out-of-State Intentional Program Violations. TW staff submit this form to CDU upon discovery of a person's current IPV disqualification that was administered by another state. See B-941, Disqualifying a Household Member with a Current SNAP Out-of-State IPV Disqualification, for directions.
- Form OIG5038, Notice of Disqualification Decision. OIG staff submit this form to CDU indicating when a court finds a person guilty of an IPV, or a court defers adjudication and the person voluntarily signs Form OIG5036, Disqualification Consent Agreement.
- Form OIG5040/5040S, Waiver of Disqualification Hearing. OIG staff submit this form to CDU indicating when a person waives the right to an ADH.
- Form H4857, Notice of Decision, Administrative Disqualification Hearing. ADH hearing officers submit this form to CDU indicating the ADH decision that a person committed an IPV.

B—953.2 Imposing an IPV Disqualification

Revision 15-4; Effective October 1, 2015

TANF and SNAP

CDU staff has primary responsibility for enforcing IPV disqualifications upon receipt of:

- Form H1856, SNAP Out-of State Intentional Program Violations;
- Form OIG5040, Waiver of Disqualification Hearing, signed by the person;
- Form H4857, Notice of Decision, Administrative Disqualification Hearing; or
- Form OIG5038, Notice of Disqualification Decision.

CDU imposes the IPV disqualification penalty:

- by the court-specified date (as indicated on Form OIG5038);
- within 45 days of the court disqualification decision date (as indicated on Form OIG5038) if the court did not specify a disqualification date;
- within 45 days of the date the person signs Form OIG5036, Disqualification Consent Agreement;
- the first month after the date the local OIG office receives a signed Form OIG5040; or
- the month after the date the person receives Form H4857.

CDU enters the IPV disqualification details in the disqualified individual's IPV Sanction screen and:

- sends an email request to the OSS - Eligibility Operations CCC to rebudget the household's future SNAP EDG benefit amount when the interface record exceptions out of a mass update or the IPV was manually entered by OIG staff; and
- sends Form OIG5042, Notice of Disqualification Enforcement, notifying:
  - the household of:
    1. the begin and end dates of the IPV disqualification penalty period; and
    2. its new benefit amount (if applicable); and
  - TW staff of the enforcement of the IPV disqualification penalty.

When an IPV disqualification is not imposed in a timely manner, CDU staff initiate an overpayment referral to establish an agency error overpayment claim for any months the household received benefits to which it was not entitled.

B—953.3 Amendment of IPV Disqualification Penalties

Revision 15-4; Effective October 1, 2015

All Programs

CDU staff are authorized to modify IPV disqualification information if applicable. TW staff should contact CDU if TW staff believe IPV information is incorrect. CDU will research and respond to the problem.

B-960, Fiscal Management Services Responsibilities

Body

Revision 11-4; Effective October 1, 2011

B—961 IPV Claim Collection

Revision 15-4; Effective October 1, 2015

All Programs

FMS establishes repayment agreements and collects on IPV claims including court-deferred adjudications.

TANF

When the person fails to comply with its repayment agreement, FMS initiates recoupment at 10 percent of the household's recognizable needs.

SNAP

When the person fails to comply with its repayment agreement, FMS initiates recoupment at 20 percent of the household's allotment or $10, whichever is greater. When a current household member is disqualified for an IPV, recoupment is computed using the allotment the household would receive if the disqualified member were included in the household size.

B-970, HHSC Employee Fraud

Body

Revision 20-4; Effective October 1, 2020

All Programs

Staff are responsible for reporting allegations of fraud involving HHSC benefit program certification procedures by HHSC employees to the unit supervisor. The supervisor forwards the report to the program manager.

Program managers report serious violations of HHSC employee fraud to the Office of Inspector General (OIG) Benefits Program Integrity (BPI). The information is reviewed and referred to the OIG Internal Affairs division, as appropriate.

Note: Allegations of employee fraud must be reported by sending a secure email or a fax to 512-833-6484.

B-980, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

All Programs

Staff must document the reason(s) for creating a fraud or IPV referral in the case comments.

Note: If the reason contains confidential information and/or the person making the allegation requests to remain anonymous, the referral must be submitted using ASOIG. Any supporting information and/or evidence should be attached to the referral using ASOIG. The TIERS referral interface does not allow for attachments. Staff must follow instructions in B-771, Filing an Overpayment Referral Using Automated System for the Office of Inspector General (ASOIG).

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

B-1000, Fair Hearings

B-1010, Right to Appeal

Body

Revision 15-4; Effective October 1, 2015

All Programs

A request for a hearing is a clear expression, oral or written, by the household or its representative that indicates that the household wishes to appeal a decision. The freedom to make a request for a hearing must not be limited or interfered with in any way.

If any member of a household or the household's representative expresses dissatisfaction with a decision regarding benefits or services, the advisor takes the following actions:

- Explain the basis for the decision and the applicable policies;
- Provide the household an opportunity to have a conference with the supervisor;
- Provide the household an opportunity to request a fair hearing;
- Provide the individual with copies of all documents before the hearing that will be entered into evidence during the fair hearing; and
- Consult with the supervisor if the individual requests information the advisor considers confidential. **Note:** The individual is entitled to any information that was used to determine suspension, reduction or termination of benefits. See B-1210, Disclosure of Information, for information that is considered to be confidential.

The household or the household's representative must make a request to withdraw an appeal in writing. Staff must fax the written withdrawal request to the designated hearings office. If a written withdrawal request is not obtained, staff must notify the hearings officer via email. If email is not an option, staff must notify the hearings officer via fax or phone.

SNAP

If the household requests a conference with the supervisor after a denial for expedited service, the advisor must schedule the conference within two workdays of the request, unless the household prefers a later date. The advisor must document that the household requested a later date.

B-1020, Time Period for Requesting Fair Hearing

Body

Revision 15-4; Effective October 1, 2015

All Programs

Individuals have the right to appeal within 90 days from the effective date of any Texas Health and Human Services Commission (HHSC) action. The individual's request may be oral or in writing.

Advisors may not prevent an individual from filing an appeal, even if the appeal was not requested within 90 days from the effective date of the action. Only the hearings officer has the authority to decide the timeliness of filed appeals and can accept untimely filed appeals in order to determine whether there was good cause for the delay in filing the appeal.

SNAP

The household may appeal the denial of a request to restore benefits that were lost within one year before the request. In addition, a household may appeal its current level of benefits during a certification period.

B-1030, Appeals Procedure

Body

Revision 15-4; Effective October 1, 2015

All Programs

All fair hearing requests are processed in the State Portal. The local office staff (including Customer Care Center [CCC] staff) and Centralized Representation Unit (CRU) staff have separate responsibilities and must follow the following procedures when processing fair hearing requests and appeals.

B—1031 Local Office Procedures for Hearing Requests

Revision 15-4; Effective October 1, 2015

When any member of a household or the household's representative expresses dissatisfaction with a decision regarding benefits or services, the local office staff takes the following actions:

- Review the Eligibility Determination Group (EDG) to determine accuracy of the action;
- Take action to correct any agency error that results in an increase in benefits;
- Clearly document any discovered error and the action taken to correct the error;
- Explain the basis for the decision and the applicable policies to the individual;
- Provide the individual an opportunity to have a conference with the supervisor (including a conference within two workdays for an individual who wants to contest an expedited services decision); and
- Provide the individual an opportunity to request a fair hearing.

The same day a fair hearing request is received:

- in person, over the telephone or in writing — the advisor/supervisor enters the fair hearing request with the Add New Appeal tab in the State Portal Appeals/RFR (Request for Revision). These entries automatically create an **Appeal Request for (Program/TOA)** for CRU staff.
- by fax or mail — the advisor/supervisor faxes or mails the appeal using the fair hearing cover sheet to the expedited fax line (1-866-559-9628) for processing. The advisor must **not:**
  - complete and submit Form H4800, Fair Hearing Request Summary;
  - enter the fair hearing request in State Portal; or
  - enter the fair hearing request through left navigation in the Texas Integrated Eligibility Redesign System (TIERS).
- advisors must consult with the supervisor if the individual requests information staff considers confidential.

B—1031.1 Office of Attorney General (OAG) Child Support Division Region Contacts

Revision 15-4; Effective October 1, 2015

OAG Region	Primary Contact	Secondary Contact	Physical Mailing and Centralized Email Addresses
1 Lubbock	Angelia Gregg 806-761-4715 Fax: 806-763-7579	Renee DeLaRosa 806-761-4704 Fax: 806-763-7579	4630 50th Street, Ste 500 Lubbock, TX 79414-3521 OAGarea1.FairHearing@texasattorneygeneral.gov

OAG Region	Primary Contact	Secondary Contact	Physical Mailing and Centralized Email Addresses
2 San Antonio	Vanessa Vasquez 210-804-6488 Fax: 210-930-3625	Martin Martinez 210-804-6489 Fax: 210-930-3625	3460 Northeast Parkway San Antonio, TX 78218-3304 OAGarea2.FairHearing@texasattorneygeneral.gov
3 McAllen	Anna Rangel 956-926-4524 Fax: 956-631-2451	Vacant	3331 N. McColl Road McAllen, TX 78501-5536 OAGarea3.FairHearing@texasattorneygeneral.gov
4 Dallas	Nancy Hernandez 214-915-3721 Fax: 214-915-3750	Oscar Sanchez 214-915-3720 Fax: 214-915-3750	400 South Zang Blvd. Ste. 1100 Dallas, TX 75208-6646 OAGarea4.FairHearing@texasattorneygeneral.gov
5 Tyler	Christy Cates 903-533-4005 Fax: 903-592-5732	Glen Elliott 903-533-4009 Fax: 903-592-5732	200 N. Broadway Avenue, Ste 355 Tyler, TX 75702-5747 OAGarea5.FairHearing@texasattorneygeneral.gov
6 Houston	Mark Jones 713-948-7673 Fax: 713-910-4806	Melissa Jimenez 713-787-7146 Fax: 713-789-7665	8866 Gulf Freeway, Ste 200 Houston, TX 77017-6529 OAGarea6.FairHearing@texasattorneygeneral.gov
7 Austin	Patricia Roark 512-358-3242 Fax: 512-892-8967	Annette Hernandez 512-358-3249 Fax: 512-892-8967	2512 S IH 35 Ste 200 Austin, TX 78704-5751 OAGarea7.FairHearing@texasattorneygeneral.gov
8 El Paso	Lorraine Sanchez-Rayas 915-782-4211 Fax: 915-782-4276	Barbara Ramirez 915-782-4236 Fax: 915-782-4276	6090 Surety Dr., Ste 250 El Paso, TX 79905-2062 OAGarea8.FairHearing@texasattorneygeneral.gov
9 Ft. Worth	Elizabeth House 817-834-7048 Fax: 817-834-7066	Kelly Robison 817-834-7038 Fax: 817-834-7066	2001 Beach St. Ste 700 Ft. Worth, TX 76103 Regional email not yet established

OAG – Counties Served by Each Area

Region	Counties Served
1 Lubbock	Archer, Armstrong, Bailey, Baylor, Briscoe, Brown, Callahan, Carson, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Comanche, Concho, Cottle, Crockett, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Eastland, Fisher, Floyd, Foard, Gaines, Garza, Grey, Hale, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Hockley, Hutchinson, Irion, Jack, Jones, Kent, Kimble, King, Knox, Lamb, Lipscomb, Lubbock, Lynn, Mason, McCulloch, Menard, Mitchell, Montague, Moore, Motley, Nolen, Ochiltree, Oldham, Parmer, Potter, Randall, Reagan, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Taylor, Terry, Throckmorton, Tom Green, Wheeler, Wichita, Wilbarger, Yoakum, Young
2 San Antonio	Atascosa, Bandera, Bexar, Comal, Dewitt, Dimmit, Edwards, Frio, Gillespie, Gonzales, Guadalupe, Karnes, Kendall, Kerr, Kinney, LaSalle, Maverick, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, Zavala
3 McAllen	Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Nueces, Starr, Webb, Zapata
4 Dallas	Collin, Cooke, Dallas, Denton, Ellis, Erath, Hood, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somerville, Tarrant
5 Tyler	Anderson, Angelina, Bowie, Camp, Cass, Chambers, Cherokee, Delta, Fannin, Grayson, Gregg, Hardin, Harrison, Henderson, Hopkins, Houston, Hunt, Jasper, Jefferson, Lamar, Liberty, Marion, Morris, Nacogdoches, Newton, Orange, Panola, Polk, Rains, Red River, Rusk, Sabine, San Augustine, San Jacinto, Shelby, Smith, Titus, Trinity, Tyler, Upshur, Van Zandt, Wood
6 Houston	Austin, Brazoria, Ft Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
7 Austin	Aransas, Bastrop, Bee, Bell, Blanco, Bosque, Brazos, Burleson, Burnett, Caldwell, Calhoun, Colorado, Coryell, Falls, Fayette, Freestone, Goliad, Grimes, Hamilton, Hays, Hill, Jackson, Lampasas, Lavaca, Lee, Leon, Limestone, Live Oak, Llano, Madison, McLennan, Milam, Mills, Refugio, Robertson, San Patricio, San Saba, Travis, Victoria, Walker, Washington, Williamson
8 El Paso	Andrews, Borden, Brewster, Crane, Culberson, East El Paso, Ector, Glasscock, Howard, Hudspeth, Jeff Davis, Loving, Martin, Midland, Pecos, Presidio, Reeves, Terrell, Upton, Ward, Winkler

B—1031.2 Providing Form H4800-A, Fair Hearing Request Summary (Addendum), to Hearings Division

Revision 17-1; Effective January 1, 2017

Form H4800-A, Fair Hearing Request Summary (Addendum), provides a method to send documents or evidence used in a hearing that were not sent with the original submission and to report changes of address or other corrections to the appropriate hearings officer.

B—1032 Centralized Representation Unit (CRU)

Revision 15-4; Effective October 1, 2015

The CRU is a staff unit within Eligibility Services Support (ESS) that represents HHSC in fair hearings and implements hearing officers' decisions.

B—1032.1 Centralized Representation Unit (CRU) Staff Responsibilities

Revision 15-4; Effective October 1, 2015

CRU staff completes the following actions:

- claim the **Appeal Request for (Program/TOA)** task from the Task List Manager (TLM) Global Queue;
- review the EDG to determine if any correction is needed and take appropriate action;
- prepare the evidence packet and mail to the Document Processing Center (DPC) for imaging;
- ensure the hearing procedures are explained in a language the individual understands;
- mail a copy of the evidence packet to the individual, legal representative, authorized representative and any other witnesses participating in the hearing;
- create and send a fair hearing request in TIERS;
- enter in TIERS any necessary accommodations; and
- mark the task as **Task Completed**.

Once the fair hearings request has been scheduled by Hearings Division staff, a **Fair Hearing Appointment for a (Program) Case** task will be routed to the Fair Hearings Centralized Representation Unit TLM Global Queue.

CRU will:

- assign an agency representative for each hearing;
- attend the fair hearing as the agency representative; and
- present the agency's case by explaining the action being appealed, the documents submitted and how the agency policy applies to the issue(s) on appeal.

B—1033 Appeals Related to Decisions/Actions of an Electronic Benefit Transfer (EBT) Vendor

Revision 14-2; Effective April 1, 2014

All Programs

When an EBT vendor cannot resolve an account balance dispute or error resolution related to benefits to an individual's satisfaction, the vendor refers the individual to Lone Star Business Services (LSBS) for a second review. The individual may contact LSBS staff to request a fair hearing if still not satisfied with the results of the second review. CRU processes the appeal following the policy and procedures outlined in this section.

B—1034 Appeals Related to Services for Medicaid Recipients

Revision 15-4; Effective October 1, 2015

All Programs

The Texas Department of State Health Services (DSHS) handles appeals concerning specific services for Medicaid recipients including:

- lock-in;
- medical necessity for prior authorization of services; and
- denial, termination, suspension or reduction of covered services, or payment for services rendered.

For individuals who want to appeal service-related issues, staff must refer them to DSHS. DSHS individual notification letters include an address and telephone number for requesting appeals. Individuals who do not have a notification letter should be referred to the Medicaid Hotline at 1-800-252-8263.

Note: DSHS does not allow individuals to appeal decisions made by the Health Insurance Premium Payment (HIPP) program. To obtain assistance in resolving problems or issues with the HIPP contractor:

- individuals must contact the Medicaid Hotline at 1-800-252-8263.
- staff must contact the Third-Party Resource (TPR) Unit at 1-800-846-7307.

B—1035 Appeals Related to Accounts Receivable Tracking System (ARTS)

Revision 15-4; Effective October 1, 2015

All Programs

For all individual requests for appeals related to ARTS collection notices, the advisor must make the following entries on Form H4800, Fair Hearing Request Summary:

1. In the **From** box, if the appeal is regarding a:
   - Claims Investigation (CI) collection notice, enter the CI unit supervisor, mail code, and phone number.
   - Treasury Offset Program (TOP) collection notice, enter ARTS Hearing Representative, 512-406-3800, at mail code E-411.

   Note: If the individual does not know if the collection notice is a result of a CI claim or TOP, enter the CI unit supervisor.
2. In Section 1, Program, check the appropriate program box.
3. In Section 2, Agency Action Resulting in a Hearing Request, check D, Not Benefit Amount Related. This will indicate to the hearing officer that the appeal does not affect current benefits.
4. In Section 8, Summary of Agency Action and Applicable Handbook Reference(s) or Rules, enter the following message: "Collection Notice - Overpayment Claim" (See B-700, Claims).

The advisor must notify the appropriate Claims Investigations Unit supervisor and ARTS supervisor of the hearing request. The advisor sends a copy of Form H4800 to the local Claims Investigation Unit supervisor or the ARTS supervisor, as appropriate, and faxes a copy of Form H4800 to ARTS at 512-438-3061.

B-1040, Timely Action on Fair Hearings

Body

Revision 15-4; Effective October 1, 2015

All Programs

Hearing decisions must comply with federal law and regulations and be based on the evidence and testimony of the hearing.

Once the fair hearing has been held and a decision rendered, the hearings officer records the decision in TIERS, and a TLM task is created and routed to the Fair Hearings Centralized Representation Unit TLM Global Queue for processing.

1. If the decision is reversed, a Process Fair Hearings Reversal Decision for (Program/TOA) TLM task is created and routed to the CRU TLM Global Queue.
2. If the decision is sustained, a Fair Hearings Sustain Decision for (Program/TOA) task will be created and routed to the CRU TLM Global Queue for processing.
3. A Fair Hearings Decision Issued for (Program/TOA) task will be created for issued decisions that do not typically require an agency action.

CRU will follow these procedures to timely implement the hearing officer's instructions:

If the hearing decision results in restored benefits, an increase in benefits for the current month and/or future months, and ...	**then ...**
no additional information or verification is needed,	ensure within 10 days from the date the decision task is received that: • benefits for future months are increased, and • all benefits the household is entitled to are provided.

If the hearing decision results in restored benefits, an increase in benefits for the current month and/or future months, and ...	then ...
	Authorize restored Temporary Assistance for Needy Families (TANF) benefits in Eligibility or by manual issuance within 10 days from the date Form H4807, Action Taken on Hearing Decision, is received.
additional information or verification is needed,	send the individual Form H1020, Request for Information or Action, **within 10 days** from the date the decision task is received. List on Form H1020 the **specific** information/verification needed in order to provide benefits. If the individual: • provides all of the requested information and verification, then increase benefits for future months and/or provide benefits for the current/past months within **three workdays** from receipt of the information/verification; • provides part but not all of the requested information and verification, then increase benefits for future months and/or provide benefits for each month for which information/verification is provided **within three workdays** of receipt of the remaining information/verification; or • fails to provide the requested information and/or verification, then follow the normal eligibility determination process in B-600, Changes, and complete/deny the EDG without the missing information/verification.

Notes:

- Upon the individual's request, CRU will offer reasonable assistance in obtaining the necessary verification. The individual's statement is acceptable as verification if no other documentary or collateral information is available.
- Restored benefits are not denied for any months solely because a person outside the household refuses to cooperate in providing verification.

SNAP

- Benefits are not restored for any months more than 12 months prior to the date a fair hearing was requested.
- If the hearing officer authorized restored benefits, TIERS sends Form H1825, Entitlement to Restored Benefits, to the household, along with a copy to the hearing officer, when benefits are approved either in Eligibility or by manual issuance.

B—1041 Completing and Reporting Timely Action on Fair Hearings

Revision 15-4; Effective October 1, 2015

SNAP

Once all restored and/or supplemental benefits have been issued, the advisor must:

- enter all decision implementation information in TIERS in the Decision Implementation page;
- clear any delays entered in the Implementation Delay page; and
- enter all necessary information in the Implementation Details page and submit for supervisor review.

The supervisor must:

- review the EDG information and all supporting documentation in accordance with agency procedures and time frames; and
- approve the Implementation Details page.

B-1050, Handling of Benefits During the Appeal Process

Body

Revision 01-3; Effective April 1, 2001

B—1051 Continued Benefits

Revision 15-4; Effective October 1, 2015

All Programs

Households previously certified for ongoing benefits are entitled to continued benefits if they make a timely request for a fair hearing after receiving Form TF0001, Notice of Case Action. A request is timely if it is made within 13 days of the adverse action notice (including a mailed request postmarked during the 13-day period). If a household fails to make a timely request for a hearing, but has good cause for the failure, benefits are reinstated at the previous level if the household did not waive its right to continue benefits.

TANF and Medical Programs

Households receiving an adequate notice of adverse action are not entitled to continued benefits when benefits are lowered or denied because of reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice).

Exception: If the household received a notice of adverse action based on noncompliance with child support or Choices, continued benefits are allowed if the individual timely requests a fair hearing.

SNAP

Households receiving a notice of adverse action are not entitled to continued benefits when benefits are lowered or denied because of:

- a verbal request to voluntarily withdraw, conducted in the advisor's presence;
- verification provided by the household that was previously postponed during expedited services;
- the household's failure to provide verification postponed during expedited services; or
- the expiration of the certification period.

B—1052 Waiver of Continued Benefits

Revision 13-3; Effective July 1, 2013

All Programs

The household may waive its right to continued benefits by providing a signed and dated statement to this effect. If the household waives this right, TIERS will reduce or deny benefits when the 13-day notice period (plus 2 days mail time) expires in advance notice situations.

B—1053 Reducing or Ending Benefits Before the Hearing Decision

Revision 15-4; Effective October 1, 2015

All Programs

Continued or reinstated benefits must not be reduced or denied during the appeal period before the official hearing decision unless:

- another change adversely affects the household and the household does not appeal the adjustment for the later change. Benefits are reduced based on the change, and the advisor sends Form TF0001, Notice of Case Action.
- a mass change affects the household's eligibility. Benefits should be adjusted accordingly.

SNAP

When a certification period expires and the household reapplies, the EDG is certified at the appropriate level of benefits.

If the hearing officer determines the only issue being appealed is federal law or regulation and there are no computation errors or misapplied law, the hearing officer instructs the advisor to reduce or deny benefits as required by the policy change.

B—1054 Time Frame to Stop Providing Continued Benefits

Revision 15-4; Effective October 1, 2015

All Programs

When a hearing officer's decision sustains the agency action, CRU must take action to stop continued benefits and file a claim for any overpayment within 10 days of receiving the hearing decision and order. Advance notice is not provided. If the hearing decision and order are received within 10 days before cutoff, CRU must make every attempt to process the EDG action before cutoff to prevent issuing continued benefits in the next month.

B-1060, Fair Hearings Held by Telephone

Body

Revision 15-4; Effective October 1, 2015

All Programs

Fair hearings may be conducted by telephone. However, an appellant may still request a face-to-face hearing. Upon requesting a face-to-face hearing, the appellant is notified of the date, time and location of the hearing using Form H4803, Notice of Hearing.

There are two versions of Form H4803 that indicate how a fair hearing is conducted:

If the fair hearing is scheduled using ...	then ...
Form H4803-T/H4803-TS, Notice of Hearing,	the hearing officer calls the appellant, the agency representative and all other fair hearing participants at the time, date and telephone number indicated on the form.
Form H4803-P, Notice of Hearing,	the appellant, agency representative and all other fair hearing participants must call the Fair Hearing 1-800-Call-In number, using the toll-free number and access code at the scheduled time indicated on the form.

B-1070, Administrative and Judicial Reviews

Body

Revision 15-4; Effective October 1, 2015

All Programs

Effective September 1, 2007, if an individual expresses dissatisfaction with a decision rendered by the fair hearings officer, the individual may have the right to have the decision reviewed. The types of review to which the individual may be entitled are an administrative review and a judicial review, depending on which program is appealed.

If the individual or individual's authorized representative is dissatisfied with a …	then the individual is entitled to an administrative review.	then the individual is entitled to a judicial review.
Supplemental Nutrition Assistance Program (SNAP) or Medicaid fair hearing decision,	Yes	Yes
TANF fair hearing decision,	Yes	No
SNAP administrative disqualification hearing (ADH) decision,	Yes	Yes
TANF ADH decision,	No	Yes

B—1071 Administrative Review

Revision 15-4; Effective October 1, 2015

All Programs

An administrative review is a review of the hearing record conducted by an agency attorney to determine if the hearing officer's decision was correct. The agency attorney issues a new decision, which includes the hearings officer's signature in all administrative reviews, and this decision is the agency's final action. Administrative reviews apply to SNAP, TANF and Medicaid fair hearing decisions and SNAP ADH decisions.

If the individual or individual's authorized representative is dissatisfied with a fair hearing decision issued on or after September 1, 2007, an administrative review may be requested but must be submitted in writing within 30 calendar days from the date of the hearing officer's decision. The request for an administrative review must be mailed to the following address:

Hearings Administrator
P.O. Box 149030, Mail Code W-613
Austin, TX 78714-9030

Notes:

- For TANF fair hearings, the individual's request for an administrative review only requires that the agency attorney review the hearing record for procedural and programmatic accuracy. The case is returned to the fair hearing officer for the final decision.
- An administrative review of the fair hearing or ADH decision by an agency attorney must be requested and completed before a judicial review is allowed. **Exception**: There is no prerequisite for an administrative review for a TANF ADH before a judicial review is requested.

B—1071.1 Centralized Representation Unit (CRU) Staff Responsibilities Following an Administrative Review

Revision 15-4; Effective October 1, 2015

All Programs

CRU Staff

When a fair hearing decision is reversed because of an administrative review, the agency must take action on the agency attorney's decision, as described in B-1040, Timely Action on Fair Hearings.

CRU:

- completes actions as required by the administrative review decision; and
- notifies the agency attorney and hearing officer that the required action has been completed.

Note: Continued benefits are not provided if the hearing officer sustains the agency action.

CRU Supervisory Staff

The CRU supervisor reviews the actions taken on the reversal and ensures all actions are complete and correct.

B—1072 Judicial Reviews

Revision 15-4; Effective October 1, 2015

All Programs

A judicial review is a review of the hearing decision by the court to determine whether the decision taken by the agency was correct. ADH decisions must be filed by the individual in a district court in Travis County. The court will determine whether the decision of the agency is correct. The individual must file a petition for a judicial review within 30 calendar days after the date the administrative review decision is rendered. The individual must complete the administrative review process before filing a petition for a judicial review.

An individual dissatisfied with a TANF ADH decision has the right to file for a judicial review in the district court in the county in which the violation occurred no later than the 30th calendar day after the date the hearing officer makes the determination.

Exception: There are no judicial review rights for a TANF fair hearing decision, but the appellant may still request a procedural review of the hearing officer's decision. A procedural review is a review of the hearing record by an agency attorney to ensure procedural and programmatic accuracy.

B—1072.1 Agency Staff Responsibilities Following a Judicial Review

Revision 15-4; Effective October 1, 2015

All Programs

Local Office and CCC Staff

If the agency's decision is reversed as a result of a judicial review, staff must implement the decision within the time frames as specified within the final orders of the court.

Note: Continued benefits are not provided due to a request for a judicial review.

B-1080, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must verify that the household waived its right to continued benefits according to B-1052, Waiver of Continued Benefits.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

B-1090, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must document the reason why the household is not entitled to continued benefits according to B-1051, Continued Benefits.

Related Policy

Documentation, C-940
The Texas Works Documentation Guide

B-1100, Reserved for Future Use

B-1200, Confidentiality

B-1210, Disclosure of Information

Body

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must disclose information to applicants or individuals who want to review their case records for information used in the eligibility determination. Advisors must withhold confidential information from the case record, such as:

- names of persons who disclosed information about the household without the household's knowledge, and

- the nature or status of pending criminal prosecution.

TANF and Medical Programs

Advisors must disclose information about applicants or individuals to federal, state, or local agencies, if the information is directly connected with:

- administration of a program approved under any of the following titles of the Social Security Act:
  - Title IV-A (Temporary Assistance for Needy Families [TANF]/Choices)
  - Title IV-B (Child Protective Services [CPS])
  - Title IV-D (Child Support)
  - Title IV-E (Foster Care and Adoption Assistance)
  - Title XVI (Supplemental Security Income [SSI])
  - Title XIX (Medicaid)
  - Title XX (Social Services/Child Care)

Disclosure of information is permitted for any case audits, reviews of expenditure reports, financial reviews, investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of these programs.

- administration of any other federal or federally assisted program that provides assistance directly to individuals on the basis of need.

Individuals or the representatives of these agencies may review the individuals' case records in the advisor's office or receive a reply in writing. Information furnished to these agencies must be:

- factual,
- sufficiently current to serve its purpose, and
- limited to the purpose of the disclosure.

In a written reply, the inquiring agency must:

- agree to keep the information confidential, and
- use the information only for the purpose stated in its request.

Advisors must disclose information about applicants or individuals to Medicaid providers or their contractors that is needed for the providers to submit claims for reimbursement of Medicaid services provided to individuals. See the list of releasable data items in B-1230, Releasable Information for Medicaid Providers and Their Contractors.

SNAP

Advisors must disclose information about applicants or individuals to persons or agencies directly connected to the administration or enforcement of:

- the Supplemental Nutrition Assistance Program (SNAP);
- food distribution programs for households on Indian reservations; or
- other federal assistance programs or federally aided programs that base assistance on an individual's income and resources.

  Such programs include, but are not limited to: Women, Infants, and Children (WIC); TANF; Medicaid; Child Protective Services; and SSI.

Advisors must disclose information about applicants or individuals to employees of the U.S. Comptroller General's Office for audit purposes.

Individuals or the representatives of these agencies may review the individuals' case records in the advisor's office or receive a reply in writing. Information furnished to these agencies must be:

- factual,
- sufficiently current to serve its purpose, and
- limited to the purpose of the disclosure.

In a written reply, the inquiring agency must:

- agree to keep the information confidential, and
- use the information only for the purpose stated in its request.

B—1211 Reporting Abuse and Neglect

Revision 15-4; Effective October 1, 2015

All Programs

Policies on confidentiality do not prohibit reporting abuse or neglect that threatens the health or welfare of a child or an elderly adult or adult with disabilities. Advisors must report instances of suspected:

- physical or mental injury,
- sexual abuse,
- exploitation, and
- neglect.

Exception: Advisors are not required to report family violence.

Advisors must inform adults or their personal representative (PR) when reporting abuse or neglect of an adult, unless the advisor believes that informing the individual or PR would place the individual at risk of serious harm.

B—1212 Personal Representatives

Revision 15-4; Effective October 1, 2015

All Programs

Only the individual's PR can exercise the individual's rights with respect to individually identifiable health information. Therefore, only an individual's PR may authorize the use or disclosure of individually identifiable health information or obtain individually identifiable health information on behalf of an individual. Individually identifiable health information is information that identifies or could be used to identify an individual and that relates to the:

- past, present, or future physical or mental health or condition of the individual;
- provision of health care to the individual; or
- past, present, or future payment for the provision of health care to the individual.

Note: An authorized representative (AR) is not automatically a PR.

B—1212.1 Adults and Emancipated Minors

Revision 15-4; Effective October 1, 2015

All Programs

If the individual is an adult or emancipated minor, including married minors, the individual's personal representative is a person who has the authority to make health care decisions about the individual and includes a:

- person the individual has appointed under a medical power of attorney, a durable power of attorney with the authority to make health care decisions, or a power of attorney with the authority to make health care decisions;
- court-appointed guardian for the individual; or
- person designated by law to make health care decisions when the individual is in a hospital or nursing home and is incapacitated or mentally or physically incapable of communication. Advisors follow regional procedures to contact the regional attorney for approval.

B—1212.2 Unemancipated Minors

Revision 15-4; Effective October 1, 2015

All Programs

A parent is the personal representative for a minor child except when:

- the minor child can consent to medical treatment by him or herself. Under these circumstances, do not disclose to a parent information about the medical treatment to which the minor child can consent. A minor child may consent to medical treatment by him or herself when the:
    - minor is on active duty with the US military;
    - minor is age 16 or older, lives separately from the parents and manages his own financial affairs;

- consent involves diagnosis and treatment of disease that must be reported to the local health officer or the Texas Department of State Health Services;
- minor is unmarried and pregnant and the treatment (other than abortion) relates to the pregnancy;
- minor is age 16 or older and the consent involves examination and treatment for drug or chemical addiction, dependency or use at a treatment facility licensed by the Texas Council on Alcohol and Drug Abuse;
- consent involves examination and treatment for drug or chemical addiction, dependency or use by a physician or counselor at a location other than a treatment facility licensed by the Texas Council on Alcohol and Drug Abuse;
- minor is unmarried, is the parent of a child, has actual custody of the child and consents to treatment for the child; or
- consent involves suicide prevention or sexual, physical or emotional abuse.

- a court is making health care decisions for the minor child or has given the authority to make health care decisions for the minor child to an adult other than a parent or to the minor child. Under these circumstances, the advisor must not disclose to a parent information about the health care decisions not made by the parent.

B—1212.3 Deceased Individuals

Revision 15-4; Effective October 1, 2015

All Programs

The PR for a deceased individual is an executor, administrator, or other person with authority to act on behalf of the individual or the individual's estate. These individuals include:

- an executor, including an independent executor;
- an administrator, including a temporary administrator;
- a surviving spouse;
- a child;
- a parent; and
- an heir.

Advisors may consult the regional attorney with questions about whether a particular person is the PR of an applicant or individual.

B—1213 Establishing Identity for Contact Outside the Interview Process

Revision 15-4; Effective October 1, 2015

All Programs

All information the Texas Health and Human Services Commission (HHSC) has about an individual or any person on the individual's case must be kept confidential. Confidential information includes, but is not limited to, individually identifiable health information.

Before discussing or releasing information about an individual or any person on the individual's case, steps must be taken to reasonably ensure that the person receiving the confidential information is either the individual or a person the individual authorized to receive confidential information (such as an attorney or personal representative).

Related Policy

Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

B—1213.1 Telephone Contact

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must establish a person's identity when contacting the individual, AR or PR by telephone. Refer to A-2020, Authenticating a Caller, for identity authentication policy.

Advisors must establish the identity of attorneys or legal representatives by asking the individual to provide Form H1826, Case Information Release, completed and signed by the individual. Advisors refer to B-1220, Specific Information That May Be Released, for authorization

requirements.

Establish the identity of legislators or their staff by following regional procedures.

Related Policy

Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

B—1213.2 In-Person Contact

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must establish the identity of a person who presents himself as an individual or individual's representative at a local eligibility determination office by:

- driver's license,
- date of birth,
- Social Security number (SSN), or
- other identifying information.

Advisors must establish the identity of other staff, federal agency staff, researchers, or contractors by:

- employee badge, or
- government-issued identification card with a photograph.

Advisors must identify the need for other staff, federal staff, research staff, or contractors to access confidential information through:

- official correspondence or phone call from state or regional offices, or
- contact with a regional attorney.

Advisors must contact appropriate regional or state office staff when federal agency staff, contractors, researchers, or other staff, etc., come to the office without prior notification or adequate identification and request permission to access HHSC records.

B-1220, Specific Information That May Be Released

Body

Revision 23-2; Effective April 1, 2023

All Programs

Staff must **only** give individual addresses or other case information to a person with written permission from the applicant to obtain the information.

Note: If a general release is authorized, the advisor must provide the information that can be disclosed to the individual described in B-1210, Disclosure of Information, under All Programs.

The applicant authorizes the release of information by completing and signing:

- Form H1826, Case Information Release; or
- a document containing all of the following information:
  - the applicant or individual's full name including middle initial and case number or full name including middle initial and either the date of birth or Social Security number;
  - a description of the information to be released;
  - statement specifically authorizing HHSC to release the information;
  - the name of the person or agency to whom the information will be released;
  - purpose of the release;
  - an expiration event that is related to the individual, the purpose of the release, or an expiration date of the release;
  - statement about whether refusal to sign the release affects eligibility for or delivery of services;
  - a statement describing the applicant's or individual's right to revoke the authorization to release information;
  - the date the document is signed; and
  - the signature of the applicant or individual.

If the case information being released includes individually identifiable health information, the document must also inform the applicant or individual that the information released under the document may no longer be private and may be further released by the person receiving the information.

Note: Advisors must not include Form H1826 or other information release authorization documents in application packets.

Advisors must give information to government agencies conducting case audits, reviewing expenditure reports, or conducting financial reviews.

Advisors must give an applicant or individual's most recent address and place of employment to Parent Locator services in state or local offices.

Advisors must refer all requests from federal, state, or local law enforcement officials for case information to the local investigation division office.

Reasonable efforts must be made to limit the use, request, or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and operate the program.

The disclosure of individual medical information from agency records must be limited to the minimum necessary to accomplish the requested disclosure. For example, if a person authorizes release of income verification, including disability income, related case medical information must not be released unless specifically authorized by the person.

TANF and Medical Programs

Advisors must release identifying information such as the name and address of the person's friends and relatives to funeral homes, police, or agencies trying to find friends or relatives of deceased people.

Advisors reply to inquiries and complaints about the status of a person’s case from public officials or interested citizens who are acting as an agent for and have the consent of the person. The case status includes whether an application was filed, action taken by HHSC and the reason for the agency's action.

Advisors provide only the specific information stated in a summons on an Internal Revenue Service (IRS) Form 2039 to the IRS representative.

Advisors provide the following information only to the Armed Forces:

- whether a person is receiving TANF; and
- the amount of the TANF grant.

Advisors provide only the information in B-1230, Releasable Information for Medicaid Providers and Their Contractors, to Medicaid providers and their contractors. **Note:** Advisors must verify the contract with the Medicaid provider by obtaining:

- the contract with the provider; or
- a written document from the provider confirming the contract.

SNAP

Advisors release the names and addresses of participating individuals to people or agencies directly connected with nutrition education.

B-1230, Releasable Information for Medicaid Providers and Their Contractors

Body

Revision 19-3; Effective July 1, 2019

All Programs

Applicant Data	• Name • SSN* • Social Security Claim Number (SSCN or PCN)* • Date of Birth • Sex	• HHSC County Code • Category Code • Application Number • Application Disposition Date • Application Status • Client Number

Client Data	• Name • Client Number • SSN* • SSCN* • Date of Birth • Sex • HHSC County Code • Certification Date • Claims Administrator Update Date (Ins Sub Date) • Last Medical Update Date • Code for Type Change in Medical Coverage • Medicaid: ◦ Open Date ◦ Close Date ◦ Type Coverage ◦ Category ◦ Type Program ◦ Qualified Medicare Beneficiary (QMB) Indicator, if applicable ◦ Medically Needy Indicator, if applicable ◦ Client Medical Record ◦ Case Numbers (active)	• Third-Party Resource (TPR) Policy Occurs (most recent three): ◦ Ins. Policy Number ◦ Ins. Policy Sequence ◦ Ins. Information Status ◦ Type Coverage ◦ Company Number ◦ Group Number ◦ Ins. Begin Date ◦ Ins. End Date ◦ Ins. Policy Holder ◦ Ins. Employer • Medicare (Yes or No) • Texas Health Steps Data: ◦ Texas Health Steps Decision Date ◦ Dental Treatment Date ◦ Medical Screen Date • Lock-in Data (most recent six): ◦ Provider Type ◦ Provider Name ◦ Start Date ◦ Through Date
Public Assistance (PA) Case Data	• Case Number • Eligibility Determination Group (EDG) Number • Case Name • Case Status • Three Month Prior Date • End Date (For Medically Needy) • Denial Reasons **	• Type Program • Active Clients List: ◦ Client Number ◦ Name ◦ Date of Birth ◦ Sex • Three Months Prior with Spend Down (not the spend down amount)

* Staff must confirm that the number given by the requestor is correct. Staff do not release Social Security numbers.

** Only the following denial reasons can be released:

Reason
Refusal to furnish information
Failure to furnish information
Appointment not kept (application/review)
Unable to locate
Voluntary withdrawal

B-1240, Preventing Disclosure of Information

Body

Revision 15-4; Effective October 1, 2015

All Programs

If the advisor receives a request for information which cannot be released, the advisor must inform the person requesting the information about the confidentiality of case records based on federal and state laws.

If the advisor receives a subpoena to appear in court with an individual's record, the advisor must notify the supervisor about the hearing. The advisor must take the case record and appear in court. When asked to disclose information from the case record, the advisor must ask the judge to be excused from disclosing information because of the laws concerning confidentiality. The advisor must abide by the judge's ruling.

B—1241 Destruction of Confidential Material

Revision 07-3; Effective July 1, 2007

Confidential material that includes identifying information such as name, address or Social Security number must be disposed of according to local office procedures.

B-1250, Reporting Unauthorized Inspection or Disclosure of Social Security Administration-Provided Information

Body

Revision 24-4; Effective Oct. 1, 2024

All Programs

Staff who become aware of an incident of unauthorized access to or disclosure of restricted information such as IRS Federal Tax Information and verified SSA information, or confidential information must immediately contact the HHSC IRS coordinator within 24 hours of initial discovery. Send a secure email with the subject line, Urgent: SSA Data Incident Report to the HHSC IRS Coordinator Mailbox.

Related Policy

IRS FTI Security and Protection, C-1050
Reporting IRS FTI Security Incidents, C-1060

B-1260, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must verify the identity of the person who contacts the advisor with a request to disclose individually identifiable health information, using sources found in A-621, Verification Sources. In addition, Form H1826, Case Information Release, presented by a legal representative or with an employee badge, may be used to identify the person.

B-1270, Documentation Requirements

Body

Revision 26-3; Effective July 1, 2026

All Programs

Document how the person's identity was authenticated. This requirement applies when disclosing individually identifiable health information and when contact occurs outside the interview.

Document:

- The name of the personal representative (PR).
- The reason a parent is not considered a PR for an unemancipated minor.
- That the inquiring agency agrees to keep information confidential.
- That the information is limited to the purpose of the disclosure.

Related Policy

Personal Representatives, B-1212
Unemancipated Minors, B-1212.2
Documentation, C-940
The Texas Works Documentation Guide

B-1300, Nondiscrimination

B-1310, Nondiscrimination Policy

Body

Revision 15-4; Effective October 1, 2015

All Programs

The Texas Health and Human Services Commission (HHSC) does not discriminate against any applicant or participant in any aspect of program administration. All eligible households receive benefits without regard to age, race, color, sex, disability, religious creed, national origin, or political beliefs.

HHSC must:

- inform the public of this nondiscrimination policy and the applicable complaint procedures, and
- provide access to nondiscrimination information within 10 days of a request.

Individuals should be referred to the Civil Rights Office toll-free at 1-888-388-6332. Staff can email the individual's request to HHSCivilRightsOffice@hhsc.state.tx.us.

SNAP

Each certification office must display the nondiscrimination poster provided by the United States Department of Agriculture (USDA).

B-1320, Racial and Ethnic Data Collection

Body

Revision 15-4; Effective October 1, 2015

All Programs

HHSC obtains racial and ethnic information about all individuals. The racial or ethnic categories are: American Indian or Alaskan Native, Asian or Pacific Islander, black (not of Hispanic origin), Hispanic, and white (not of Hispanic origin). Individuals are requested to voluntarily identify their race or ethnicity on the applications for HHSC assistance. If this information is not voluntarily provided on the application form, the advisor must determine the category by asking an individual to self-identify the individual's race. The individual's racial identity is self-declared. If the individual does not want to provide the information, the individual's race is listed as "unknown." In the Individual Household logical unit of work (LUW) on the individual's Add New Individual Information, Edit Existing Individual ID Information **or** Edit New Individual Information page, the advisor must select the appropriate ethnicity and race from the drop-down menus.

B-1400, Complaints

B-1410, Discrimination Complaints

Body

Revision 15-4; Effective October 1, 2015

All Programs

Texas Health and Human Services (HHS) Circular C-001 found at www.hhsc.state.tx.us/news/circulars/c-001.shtml describes general discrimination complaint procedures.

SNAP

Explain the following procedures to individuals who feel they have been discriminated against in the Supplemental Nutrition Assistance Program (SNAP) and want to complain about it.

- Individuals may submit their complaint to the United States Department of Agriculture (USDA), any Texas Health and Human Services Commission (HHSC) certification office, or both. Individuals may submit complaints to, or obtain information from, USDA at either of these addresses:

Food and Nutrition Service
United States Department of Agriculture
Washington, D.C. 20250

or

Food and Nutrition Service
United States Department of Agriculture
1100 Commerce Street
Suite 5-C-30
Dallas, TX 75242

- Individuals must file their complaints in writing within 180 days of the incident that caused the complaint.

If submitting a complaint to HHSC, individuals use Form H4870, Client Complaint of Discrimination. For verbal or hotline complaints, staff accepting the complaint complete Form H4870 for the individual. Advisors and other staff handle hotline complaints the same as any other complaints.

B-1420, Office of the Ombudsman

Body

Revision 19-2; Effective April 1, 2019

All Programs

Office of the Ombudsman operates a toll-free customer service hotline during normal office hours. The Office of the Ombudsman assists the public with issues or complaints about health and human services programs that have not been resolved under the agency's normal resolution process. If a person has a problem or complaint, they are encouraged to first discuss it with the person, program staff or office staff involved. They can often explain a specific policy or resolve the concern immediately.

People who need assistance or information about local resources or programs are encouraged to call 2-1-1 for access to information about health and human services in their community, including information on the location and phone number of local HHSC offices.

If a person has problems with or complaints about a health and human services program, service, or benefit that has not been resolved to their satisfaction, the person has four ways to send a question or file a complaint:

1. **Call:** Toll-free phone, relating to:
   A. A consumer, call 877-787-8999 (8 a.m. to 5 p.m., Central Standard Time, Monday through Friday).
   B. A consumer needing help with accessing services under a managed care plan, call 866-566-8989.
   C. A foster youth, call 844-286-0769.
   D. A consumer seeking behavioral health services, call 800-252-8154.
   E. A resident of a nursing facility or an assisted living facility, call 800-252-2412.
   F. A person who has a hearing or speech disability, call 7-1-1 or 800-735-2989.
2. **Online:** hhs.texas.gov/ombudsman
3. **Fax:** 888-780-8099 (toll-free)
4. **Mail:** Texas Health and Human Services Commission
   Office of the Ombudsman, MC H-700
   P.O. Box 13247
   Austin, Texas 78711-3247

Ombudsman staff:

- provide dispute resolution services;
- perform consumer protection and advocacy functions;
- collect consumer contact data;
- conduct reviews of complaints concerning HHSC policy or practices;
- ensure case actions related to complaints are consistent with applicable HHS policies;
- provide information to people about their rights and responsibilities;
- coordinate the resolution of complaints or requests for information with appropriate agency staff;
- refer people who request other state health and human services to the appropriate area;
- screen, document and track all complaints and inquiries received using the HHS Enterprise Administrative Report and Tracking System (HEART);
- compile and share various weekly, monthly and quarterly reports with designated executive, state and regional staff, providing complaint and inquiry volume and trend analysis.

Note: Ombudsman staff cannot determine eligibility or make changes to cases.

Medicaid Managed Care Helpline

The Medicaid Managed Care Helpline is designed to help people who receive Medicaid and need help accessing health care services. The HHSC Medicaid Managed Care Helpline helps people who receive Medicaid benefits:

- navigate the managed care system (STAR, STAR+PLUS, STAR Kids and STAR Health);
- understand their Medicaid coverage;
- understand their rights;
- advocate for themselves; and
- resolve problems, including access to care.

The Medicaid Managed Care Helpline also provides general information about managed care programs to providers, health plans, community based organizations and other stakeholders. People may contact the Medicaid Managed Care Helpline at 866-566-8989.

Related Policy

Managed Care, A-821.2
Managed Care Plans, C-1116

Part C, Appendix

C-100, Income Limits and Proration Charts

C-110, TANF

Body

C-111 Income Limits

Revision 25-4; Effective Oct. 1, 2025

TANF

Temporary Assistance for Needy Families (TANF) Budgetary Allowances (Oct. 1, 2025)

Family Size	Non-Caretaker Cases			Caretaker Cases Without Second Parent			Caretaker Cases With Second Parent		
	Bud Needs (100%)	Rec Needs (25%)	Max Grant	Bud Needs (100%)	Rec Needs (25%)	Max Grant	Bud Needs (100%)	Rec Needs (25%)	Max Grant
1	$256	$64	$130	$313	$78*	$159	---	---	---
2	$369	$92	$188	$650	$163	$331	$498	$125**	$253
3	$518	$130	$263	$751	$188	$382	$824	$206	$418
4	$617	$154	$314	$903	$226	$459	$925	$231	$470
5	$793	$198	$403	$1003	$251	$510	$1073	$268	$545
6	$856	$214	$435	$1153	$288	$586	$1176	$294	$597
7	$1068	$267	$543	$1252	$313	$636	$1319	$330	$670
8	$1173	$293	$596	$1425	$356	$724	$1422	$356	$722
9	$1346	$337	$684	$1528	$382	$776	$1595	$399	$810
10	$1450	$363	$737	$1701	$425	$864	$1698	$425	$862
11	$1623	$406	$824	$1804	$451	$916	$1871	$468	$950
12	$1726	$432	$877	$1977	$494	$1,004	$1975	$494	$1,003
13	$1899	$475	$965	$2080	$520	$1,057	$2147	$537	$1,090
14	$2003	$501	$1,017	$2253	$563	$1,144	$2251	$563	$1,143
15	$2174	$544	$1,104	$2356	$589	$1,197	$2423	$606	$1,230
Each additional person	$173	$43	$88	$173	$43	$88	$173	$43	$88

* Caretaker of child receiving Supplemental Security Income (SSI)
** Caretaker and second parent of child receiving SSI
Bud Needs is budgetary needs.
Rec Needs is recognizable needs.

C-112 How to Prorate TANF Grants

Revision 22-3; Effective July 1, 2022

TANF

After eligibility is determined, the TANF grant amount is prorated for the first month of eligibility using the following steps:

1. Calculate the certified group's recommended grant amount for the month based on the household size and net income. (See Step 5, line 3, page 3 of Form H1101, TANF Worksheet, or Step 5, line 3, page 2 of Form H1102, TANF Worksheet for Special Reviews and Denials.)
2. Determine the earlier of the certification date or the 30th day after the file date. Using the chart in C-112.1, Proration Multiplier Chart, determine the appropriate proration multiplier.
3. Multiply the recommended grant amount from Step 1 by the multiplier from Step 2.
4. Round the amount from Step 3 down to the next dollar. If the resulting prorated grant is less than $10, the household is not eligible for a grant in the first month. The grant effective date is the first day of the following month.

Note: One-Time TANF and One-Time TANF for Relatives payments are not prorated.

C-112.1 Proration Multiplier Chart

Revision 01-7; Effective October 1, 2001

TANF

Date Financial Eligibility Begins	Proration Multiplier
1	1
2	.97
3	.93
4	.90
5	.87
6	.83
7	.80
8	.77
9	.73
10	.70
11	.67
12	.63
13	.60
14	.57
15	.53
16	.50
17	.47
18	.43
19	.40
20	.37
21	.33
22	.30
23	.27
24	.23
25	.20
26	.17
27	.13
28	.10
29	.07
30/31	.03

C-120, Supplemental Nutrition Assistance Program

Body

C-121 Maximum Income Limits

Revision 25-4; Effective Oct. 1, 2025

SNAP

SNAP Maximum Income Limits Effective Oct. 1, 2025

Household Size	Gross (130%)	Net (100%)	165%*
1	$1,696	$1,305	$2,152
2	$2,292	$1,763	$2,909
3	$2,888	$2,221	$3,665
4	$3,483	$2,680	$4,421
5	$4,079	$3,138	$5,177
6	$4,675	$3,596	$5,934
7	$5,271	$4,055	$6,690
8	$5,867	$4,513	$7,446
9	$6,463	$4,972	$8,203
10	$7,059	$5,431	$8,960
Each additional person	$596	$459	$757

* The figures in the 165 percent column are used to determine if a person:

- who is elderly; or
- with a disability living with others;

may claim separate household status even though the person purchases or prepares food with the others.

The figures in this column are also the income limits for categorically eligible households.

C-121.1 Deduction Amounts

Revision 25-4; Effective Oct. 1, 2025

SNAP

Use the following deductions amounts when determining the household's budget:

- Standard deduction. For household's with:
  - three or less members, deduct $209.
  - four members, deduct $223.
  - five members, deduct $261.
  - six or more members, deduct $299
- Standard medical expense (SME) of $170, minus $35.
- Actual medical expense, minus $35.
- Homeless shelter standard deduction of $198.99.
- Maximum excess shelter deduction of $744.
- Standard utility allowance (SUA) of $445.
- Basic utility allowance (BUA) of $400.
- Telephone standard deduction of $62.

Note: A disqualified member in the household size is not used when applying the standard deduction.

Related Policy

Deductions, A-1400

C-122 How to Determine Monthly SNAP Allotments

Revision 25-4; Effective Oct. 1, 2025

SNAP

Use the whole monthly allotments by household size chart to determine the monthly allotment. Add $218 for each additional person to the whole monthly allotment to calculate the monthly allotment for a household with more than 10 people.

Determine the monthly allotment by:

- multiplying the household's net monthly income by .30;
- rounding the cents to the next higher whole dollar amount; and
- subtracting the rounded sum from the maximum monthly allotment for the household size.

Example: To determine the monthly allotment of a 12-person household with a net monthly income of $964:

- $964 X .30 = 289.2;
- $289.2 is rounded to the next whole dollar amount of $290; and
- $2,661 - $290 = $2,371 whole monthly allotment.

Related Policy

Whole Monthly Allotments by Household Size, C-1431
Prorated SNAP Allotments by Application Date, C-1432

C-123 How to Prorate Benefits

Revision 25-4; Effective Oct. 1, 2025

SNAP

Use the prorated SNAP allotments by application date chart to determine a prorated allotment.

Determine the prorated allotment by:

- subtracting the application date from 31;
- multiplying that sum by the amount of the whole monthly allotment;
- dividing that amount by 30; and
- rounding the cents down to the nearest lower whole dollar by disregarding all cents.

Example: To determine the prorated allotment for a household with a whole monthly allotment of $395 and an application date of June 17:

- 31 - 17 = 14;
- 14 x $395 = $5,530;
- $5,530 ÷ 30 = $184.33; and
- $184.33 is rounded down to the nearest lower whole dollar amount of $184 for the prorated allotment.

Note: Use 30 and 31 days as described above no matter the number of days in the prorated month.

Some categorically eligible households can receive ongoing monthly allotments of less than $10. Do **not** issue allotments prorated to less than $10. A one-or two-person household that qualified for a minimum monthly allotment of $24 can receive a prorated allotment of less than $24. It cannot be a prorated allotment of less than $10.

Do not prorate benefits if the household includes a member who meets both of the following criteria:

- is a seasonal or migrant farm worker who is in or out of the workstream; and
- was certified for SNAP in Texas or another state the month before the household applied.

Related Policy

Whole Monthly Allotments by Household Size, C-1431
Prorated SNAP Allotment by Application Date, C-1432

C-130, Medical Programs

Body

C–131 Income Limits

Revision 13-3; Effective July 1, 2013

C–131.1 Federal Poverty Level (FPL)

Revision 26-2; Effective April 1, 2026

TP 33, TP 34, TP 35, TP 36, TP 43, TP 44, TP 48, TP 40, TP 42, TA 74, TA 75 and TA 76

Family Size	133% FPL March 1, 2026 TP 44, 34, TA 76	144% FPL March 1, 2026 TP 48, 33, TA 75	198% FPL March 1, 2026 TP 40, 42, 43, 36, 35, TA 74
1	$1,769	$1,916	$2,634
2	$2,399	$2,597	$3,571
3	$3,028	$3,279	$4,508
4	$3,658	$3,960	$5,445
5	$4,288	$4,642	$6,383
6	$4,917	$5,324	$7,320
7	$5,547	$6,005	$8,257
8	$6,176	$6,687	$9,194
9	$6,806	$7,368	$10,131
10	$7,435	$8,050	$11,069
11	$8,065	$8,732	$12,006
12	$8,694	$9,413	$12,943
13	$9,324	$10,095	$13,880
14	$9,953	$10,776	$14,817
15	$10,583	$11,458	$15,755
For each additional person	$630	$682	$938

Note: Refer to C-1114, Guidelines for Providing Retroactive Coverage for Children and Medical Programs, for the income limits.

TA 41, TA 84 (CHIP), TA 85 (CHIP-P), TA 77 and TP 70

Family Size	201% FPL March 1, 2026 TA 84	202% FPL March 1, 2026 TA 85	204.2% FPL March 1, 2026 TA 41	400% FPL March 1, 2026 TA 77	413% FPL March 1, 2026 TP 70
1	$2,674	$2,687	$2,716	$5,320	$5,493
2	$3,625	$3,643	$3,683	$7,214	$7,448
3	$4,577	$4,599	$4,649	$9,107	$9,403
4	$5,528	$5,555	$5,616	$11,000	$11,358
5	$6,479	$6,512	$6,583	$12,894	$13,313
6	$7,431	$7,468	$7,549	$14,787	$15,268
7	$8,382	$8,424	$8,516	$16,680	$17,223
8	$9,334	$9,380	$9,482	$18,574	$19,177
9	$10,285	$10,336	$10,449	$20,467	$21,132
10	$11,236	$11,292	$11,415	$22,360	$23,087
11	$12,188	$12,248	$12,382	$24,254	$25,042
12	$13,139	$13,205	$13,348	$26,147	$26,997
13	$14,091	$14,161	$14,315	$28,040	$28,952
14	$15,042	$15,117	$15,281	$29,934	$30,907
15	$15,993	$16,073	$16,248	$31,827	$32,862
For each additional person	$952	$957	$967	$1,894	$1,955

C–131.2 Medically Needy and Parents and Caretaker Relatives Medicaid

Revision 15-4; Effective October 1, 2015

TA 31, TP 08, TP 32, TP 56 and TA 86

-	-	TP 08, TA 31 and TA 86	
Family Size	TP 32 and TP 56	One Parent	Two Parents
1	$104	$103	N/A
2	$216	$196	$161
3	$275	$230	$251
4	$308	$277	$285
5	$357	$310	$332
6	$392	$356	$367

-	-	TP 08, TA 31 and TA 86	
Family Size	**TP 32 and TP 56**	**One Parent**	**Two Parents**
7	$440	$389	$412
8	$475	$441	$447
9	$532	$476	$500
10	$567	$527	$535
11	$624	$562	$587
12	$659	$613	$622
13	$716	$648	$675
14	$751	$700	$710
15	$808	$734	$762
Per each additional member	$57	$52	$52

C–131.3 Transitional Medicaid

Revision 26-2; Effective April 1, 2026

TP 07

Family Size	185% FPL March 1, 2026 TP 07
1	$2,461
2	$3,337
3	$4,212
4	$5,088
5	$5,964
6	$6,839
7	$7,715
8	$8,591
9	$9,466
10	$10,342
11	$11,218
12	$12,093
13	$12,969
14	$13,845
15	$14,720
For each additional person	$876

C–131.4 Standard MAGI Income Disregard

Revision 26-2; Effective April. 1, 2026

Five Percentage Points of FPL

Family Size	2026 Monthly Disregard Amount
1	$66.50
2	$90.20
3	$113.85
4	$137.50
5	$161.20
6	$184.85
7	$208.50
8	$232.20
9	$255.85
10	$279.50
11	$303.20
12	$326.85
13	$350.50

Family Size	2026 Monthly Disregard Amount
14	$374.20
15	$397.85
For each additional person	$23.70

C–131.5 IRS Monthly Income Thresholds

Revision 26-2; Effective April 1, 2026

Each year, the Internal Revenue Service (IRS) establishes income thresholds for earned and unearned income. People whose earned, unearned or combined income exceeds the federal income tax filing threshold must file a federal income tax return under federal law. Use the IRS monthly income thresholds to determine if a person's income must be counted when calculating Modified Adjusted Gross Income (MAGI) financial eligibility. This is explained under Medical Programs, Step 3, in A-1341, Income Limits and Eligibility Tests.

Determine if a person must file a federal income tax return by comparing the specified income types to the IRS thresholds in the following table.

Type of Income	2026 Threshold	Apply Threshold Value in Form H1042, Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP
Unearned Income	$112.50	• Page 4-6, Step 3, Part 7 • Page 4-6, Step 3, Part 9
Earned Income	$1,312.50	Page 4-6, Step 3, Part 8

C-200, Opening, Denial, and Reinvestigation Codes (Retired as of July 1, 2013)

C-210, TANF Codes

Body

C-211 Opening Codes

Revision 02-3; Effective April 1, 2002

TANF

Select a code for the occurrence during the six months prior to certification that is the primary reason the household needs Temporary Assistance for Needy Families (TANF). Use these codes only in Item 132 on Form H1000-A, Notice of Application.

Code	Description
024	Use this code to open a case previously denied because of a lump sum if the household becomes eligible because its period of ineligibility is shortened.

Earnings Lost or Reduced in the Last Six Months Because ...

Code	Description
025	**Father Incapacitated** Earnings of the father in the home have terminated or decreased because of his illness, injury, or impairment. The onset of the disability may have occurred prior to the last six months. The disabled father must be in the home unless he is receiving medical treatment out of the home.
026	**Mother Incapacitated** Earnings of the mother in the home have terminated or decreased because of her illness, injury, or impairment.
027	**Other Caretaker Incapacitated** Earnings of the children's caretaker in the home, other than the father or mother, have terminated or decreased because of the caretaker's illness, injury, or impairment. Use this code if the caretaker had been supporting the children before the loss of or decrease in earnings.
028	**Father Laid Off** Earnings of the children's father in the home have terminated or decreased because he has been laid off or discharged from

Code	Description
	his job or discontinued his self-employment.
029	**Mother Laid Off** Earnings of the children's mother in the home have terminated or decreased because she has been laid off or discharged from her job, or discontinued her self-employment.
030	**Other Caretaker Laid Off** Earnings of the children's caretaker in the home, other than the children's mother or father, have terminated or decreased because the caretaker has been laid off or discharged from a job, or discontinued self-employment. Use only if the caretaker had been supporting the children before the loss or decrease in earnings.

Support from the Caretaker Lost or Reduced in the Last Six Months Because the Caretaker ...

Code	Description
031	**Died** Use to indicate death of the caretaker who supported the children during the six months prior to death.
032	**Left Home** Use if the caretaker supported the children during the six months prior to leaving and has not provided sufficient support since leaving.
033	**Was Incarcerated** Use if the caretaker supported the children during the six months prior to incarceration.

Support from Person in the Home Other Than Father, Mother, or Other Caretaker Was Lost or Reduced in the Last Six Months Because the Person ...

Code	Description
034	**Died** Use to indicate death of the person who supported the children during the six months prior to death.
035	**Left** Use if the person supported the children during the six months prior to leaving and has not provided sufficient support since leaving.
036	**Is Incapacitated** Use if the person is unable to continue supporting the children because of the person's disability.
037	**Is Laid Off** Use if the person is unable to continue supporting the children because of a change in employment status.

Support from Person Outside the Home Lost or Reduced in the Last Six Months Because ...

Code	Description
039	**Absent Father Discontinued or Reduced the Children's Support Payments** Use if the children's father has been absent for the past six months; if father left home in the past six months, use code 032.
040	**Another Person Discontinued or Reduced the Children's Support Payments** Use if someone outside the home other than the children's father stopped or reduced the children's support payments.

Other Income Lost or Reduced in the Last Six Months Because ...

Code	Description
041	**TANF Father, Mother, or Other TANF Caretaker Lost or had a Reduction in Income Not Listed in Codes 025-040** Examples of income include RSDI; allowance, pension, or other payment connected with military service; unemployment benefits; workers' compensation; and rental income. Do not include the loss of any income based on need.

Depletion of the Family's Assets in the Last Six Months Because of ...

Code	Description
042	**Medical Care Cost** Medical care cost includes all items for medical or remedial care, including care in nursing facilities.
043	**Other Living Costs** These costs do not include medical care costs.
044	**Other Material Change** Examples of circumstances include loss of investments through business failure or loss of home or other buildings by fire. Do not use if the assets produced income that provided full or partial support. Use code 041, loss of or reduction in other income.

Code	Description
	Use if the household was previously certified under the real property exemption based on good faith effort to sell, and the family sold the property or it is no longer accessible.

No Change in Income or Resources During the Last Six Months. The Only Change in the Last Six Months Is ...

Code	Description
046	**Increased Need or Other Budget Items** A change in household composition or living arrangements resulted in increased needs for the TANF family.
047	**No Proration of Benefits** TP 01, use this code when certifying • a stepchild and his parent after they have been removed from a TANF incapacity or a TANF-SP TP 61 case that is transferring to MAO, TP 07, 37, or Medical Programs for Families and Children. See B-483 for more information. • an other-related child after he has been removed from an existing TANF/TANF-SP case. See B-482, Separating Household Members, for more information. SAVERR enters a six-month periodic review in Item 141. Use to administratively reopen a TP 01 or 61 case after denying a TP 01 or 61 case on hold in order to prevent the automated systems from counting a month(s) toward a individual's time limit. When used, • TANF grants will not be prorated, and • SAVERR will enter a six-month periodic review in Item 141.

No Change in Income or Resources During the Last Six Months. The Only Change in the Last Six Months Is ...

Code	Description
049	**The Applicant Met the Eligibility Requirement for Residence**
050	**The Applicant Met the Eligibility Requirement for Citizenship**
052	**The Applicant Met Another Technical Eligibility Requirement**
053	**The Applicant Applied for Assistance**
056	**A Change That Cannot Be Related to Codes 045-053** Example is the departure of an unemployed caretaker who has not provided support.

Administrative Opening Codes

Code	Description
054	**Post (Child Support) or Transitional Medicaid Reinstatement** Use to reinstate a denied • TP 20 household that returns to live in Texas, or • TP 07 or TP 37 household that meets the requirements in A-800, Medicaid Eligibility.
055	**Denied in Error** Use to reopen a case or application that was denied by mistake.
057	**Medicaid Administrative Opening Code** Use to open a: • TP 07, 20, 29, or 37 case • Medical Programs for Families and Children case When the TP 01 or TP 61 case on hold was denied, instead of transferred, in order to prevent the automated systems from counting a month(s) toward an individual's time limit. "Person(s) meet Medicaid eligibility requirements." "Persona(s) llena los requisitos de elegibilidad de Medicaid." For TPs 07, 29, and 37, also include the following message: "While receiving transitional Medicaid, you must report to HHSC within 10 days after you move and after anyone moves

Code	Description
	in or out of your household." "Mientras reciba Medicaid de transición, tiene que avisar a la HHSC dentro de los 10 días de su cambio de case o del cambio del número de personas de su casa."

C-212 Denial Codes

Revision 12-1; Effective January 1, 2012

TANF

Reasons for denying cases and applications are classified into three groups:

1. ineligibility because of death of a member;
2. need; and
3. miscellaneous reasons.

Select the code reflecting the primary reason for denial. If a reason related to need and another reason occur at the same time, use the need code. Enter in Item 132 of Form H1000-A, Notice of Application, and Form H1000-B, Record of Case Action.

Death (058-059)

Code	Description
058	**Death of Caretaker** No Notice.
059	**Death of Child – A-500, Age/Relationship** "You no longer have children in your home who are eligible for assistance." "Ya no hay niños en su casa que califican para asistencia."

Need (060-075)

Code	Description
060	**Earnings of Father, Legal or Stepfather — A-1323.5, Wages, Salaries, Commission and Tips** Use for applications and ongoing cases that are not eligible for post-medical coverage. "Earnings of father meet needs that can be recognized by this agency." "El padre gana suficiente para cubrir las necesidades reconocidas por esta agencia."
061	**Earnings of Mother, Legal or Stepmother — A-1323.5, Wages, Salaries, Commission and Tips** Use for applications and ongoing cases that are not eligible for post-medical coverage. "Earnings of mother meet needs that can be recognized by this agency." "La madre gana suficiente para cubrir las necesidades reconocidas por esta agencia."
062	**Earnings of TANF Child – A-1323.1, Children's Earned Income** Use for applications and ongoing cases that are not eligible for post-medical coverage. "Earnings of child meet needs that can be recognized by this agency." "Su hijo/hija gana suficiente para cubrir las necesidades reconocidas por esta agencia."
063	**Earnings of Non-Parent Caretaker — A-1323.5, Wages, Salaries, Commission and Tips** Use for applications and ongoing cases that are not eligible for post-medical coverage. "Earnings of other person in your home meet needs that can be recognized by this agency." "Una persona que vive en su casa gana suficiente para cubrir las necesidades reconocidas por esta agencia."
064	**Support from Absent Father — A-1326.1, Cash Gifts and Contributions; A-1326.2, Child Support; A-1334, Vendor Payments** (See chart in C-241, TANF and Medical Programs Chart, for appropriate reference codes.) "Income from children's father who is outside the home meets needs that can be recognized by this agency." "El padre que no vive en la misma casa manda suficiente dinero para cubrir las necesidades reconocidas por esta agencia."
065	**Pursuit of Texas Works Activities — A-1527, The Texas Works Message** "You have chosen to pursue employment opportunities and/or save your time-limited benefits for another time." "Usted decidió buscar empleo y/o usar sus beneficios de tiempo limitado en ortra occasión."
066	**Support from Other Person Outside the Home, Including Mother — A-1326.2, Child Support; A-1334, Vendor Payments** (See chart in C-241, TANF and Medical Programs Chart, for appropriate reference codes.) "Income available to you from a person outside the home meets needs that can be recognized by this agency." "El dinero que recibe de un pariente fuera de su casa es suficiente para cubrir las necesidades reconocidas por esta agencia."
067	**RSDI — A-1324.15, Retirement, Survivors, and Disability Insurance(RSDI)** "Income available to you from social security benefit meets needs that can be recognized by this agency."

Code	Description
	"El cheque que usted recibe ahora, o va a recibir, del seguro social es suficiente para cubrir las necesidades reconocidas por esta agencia."
068	**Other Federal Benefits — A-1324.19, Veterans Benefits** "Income available to you from federal benefit or pension meets needs that can be recognized by this agency." "El dinero que usted recibe ahora de beneficios o pensiones federales es suficiente para cubrir las necesidades reconocidas por esta agencia."
069	**State and Local Benefits — A-1326.9, Pensions; A-1324.18, Unemployment Compensation; A-1321.4, Workers Compensation**(See chart in C-241 for appropriate reference codes.) Includes workers' compensation, unemployment compensation, state and local government retirement benefits. "Income available to you from state or local benefit or pension meets needs that can be recognized by this agency." "El dinero que usted recibe de beneficios o pensiones de gobierno local o del estado es suficiente para cubrir las necesidades reconocidas por esta agencia."
070	**Non-Governmental Benefits — A-1326.9, Pensions** "Income available to you from pension or benefit meets needs that can be recognized by this agency." "El dinero que recibe usted de pensiones or beneficios es suficiente para cubrir las necesidades reconocidas por esta agencia."
071	**Income Not Codes 060 — 070 — A-13XX** (See chart in C-241, TANF and Medical Programs Chart, for appropriate reference codes.) **A-800, Medicaid Eligibility, for TP 07/37** "Income available to you meets needs that can be recognized by this agency." "El dinero que gana o recibe usted es suficiente para cubrir las necesidades reconocidas por esta agencia."
072	**Resources — A-12XX** (See chart in C-241, TANF and Medical Programs Chart, for appropriate reference codes.) "Resources available to you from other property meets needs that can be recognized by this agency." "Los recursos que tiene usted en propiedades or dinero son suficientes para cubrir las necesidades reconocidas por esta agencia."
074	**Fewer Members in Certified Group — A-1341, Income Limits and Eligibility Tests** "No unmet need for the current family size." "Ahora que usted tiene menos familia, sus entradas son suficientes para cubrir las necesidades reconocidas por esta agencia."
075	**Conflicting Information on Management — A-1700,Management** "Information on management indicates additional income." "Según la información que tenemos acerca de su situación económica, parece ser que usted no reportó toda su entrada."
076	**Refusal to Furnish Information — B-100, Processes and Processing Time Frames** Use only if a Form H1010-B, Application for Assistance -Part B: Information We Need Know, is on file. Use code 091 for failure to return Form H1010-B. "You did not wish to furnish enough information for this agency to establish eligibility for assistance." "Usted no quiso darnos suficiente información para poder establecer su calificación para asistencia."
077	**Refusal to Follow Agreed Plan — A-1311, Requirement to Pursue Income** Use to deny ongoing cases when an individual fails to pursue potential sources of income or resources that would be made available through the individual's efforts. "You did not wish to follow agreed plan so that eligibility for assistance could be continued." "Usted ya no califica para asistencia porque no quiso utilizar, según el plan que hablamos, otros posibles recursos."
078	**Earnings/Child Support Payments Terminate — A-800, Medicaid Eligibility** Use to deny Medicaid coverage before the end of the four- or twelve-month period for • TP 07 or TP 37 transitional Medicaid when the caretaker relative has no earnings for one month on the 7th or 10th month Medicaid Report, or • TP 20 Medicaid when child support payments terminate. "Your Medicaid coverage following denial of your grant has ended as agreed." "Como fue acordado al terminar su concesión, su calificación para los beneficios de Medicaid termina ahora."
083	**Federal Time Limits — A-1900, Federal Time Limits (FTLs)** Use to deny an application or ongoing case because a household member has received 60 months of TANF assistance. "Your household is ineligible for TANF due to federal time limits, because the following person has received 60 months of TANF cash assistance. Your family may still be eligible for Medicaid. Contact your local office for information." "Debido alos límites de tiempo federal su unidad familiar no tiene derecho a TANF porque la siguiente persona ha recibido asistencia económica de TANF 60 meses. Es posible que sue familia todavía tenga derecho a Medicaid. Comuníquese con la oficina local para recibir información."
086	**Child Admitted to Institution, Including Foster Care —A-900,Domicile** "Your child has been admitted to an institution." "Su niñoha sido admitido a un hospital u otra institución."
087	**No Eligible Child – A-900, Domicile, or A-800, Medicaid Eligibility, for TP 07/37** Use to deny applications or ongoing cases because the child does not meet relationship requirements or is no longer in the

Code	Description
	home. "You no longer have children in your home who are eligible for assistance." "Usted ya no tiene niños en su casa que califican para asistencia."
088	**Residence Requirement Not Met — A-700, Residence** Use for applications and for ongoing cases when the household moves out of state. "Residence requirements are not met." "Sus niños no califican para asistencia porque no cumplen con el requisito de residencia en el estado."
089	**Citizenship or Acceptable Alien Status — A-300, Citizenship** "Your children do not meet acceptable alien status or citizen requirements for assistance." "Sus niños no son elegibles para asistencia porque no cumplen con el requisito de ciudadanía ni de inmigrante elegible."
090	**Prior Eligibility — A-800, Medicaid Eligibility; A-1900, Federal Time Limits (FTLs); A-2400, One Time Payments** • Use to authorize Medicaid or TANF warrants for ◦ denied households eligible for restored benefits. ◦ deceased individuals. ◦ individuals eligible for three months prior Medicaid only. ◦ applicants eligible for Medicaid for the application month but ineligible for TANF or Medicaid for the month following the application month. ◦ applicants eligible for TANF and Medicaid for the current month but ineligible for future months. "Assistance was granted during a prior period, but you are not eligible now for medical or financial assistance." "Usted calificó anteriormente para asistencia pero ahora ya no califica para asistencia económica ni para beneficios médicos." • Use to open and close TP 37 between cutoff in the 11th and 12th months. "Your original period of transitional Medicaid has been reinstated." "Su cobertura bajo Medicaid de transición ha sido aprobada de nuevo para el periodo originalmente especificado." • Use to authorize OTTANF benefits. "Your family will receive $1,000 for mm/dd/yy. Your family will be ineligible to apply for TANF, TANF-SP, or OTTANF until mm/dd/yy."
091	**Failure to Furnish Information — B-100, Processes and Processing Time Frames** Use this code if the applicant/individual fails to return the application form. "You failed to complete and return the necessary eligibility form." "Usted no ha entregado la forma completa que necesitamos para determinar su elegibilidad para asistencia."
092	**Other Eligibility Requirements — A-132, Eligibility Factors** Use to deny applications and ongoing cases for reasons other than need but not covered by codes 076-091. It cannot be entered by advisors to deny medical assistance only cases. "You do not meet eligibility requirements for assistance." "Usted no califica para asistencia." **Note:** SAVERR enters this code at the end of the Medicaid period for TP 07, TP 20 and TP 37. "Your Medicaid coverage has ended." "Su cobertura de Medicaid ha terminado."
093	**Adult Earnings (Refugee Only) — R-700, Age/Relationship** Use to deny RCA applications and ongoing cases that are not eligible for post medical coverage. Use only if the case is an adult case with no children. "You will not be eligible for Medicaid after mm/dd/yy." "La elegibilidad para Medicaid termina el mm/dd/yy."
094	**Appointment Not Kept, Application/Review — B-100, Processes and Processing Time Frames** "You failed to keep your appointment." "Usted no vino a la cita que le dimos."
095	**Unable to Locate — A-700, Residence** "You cannot be located." "No podemos localizar al solicitante."
096	**Refugee Exceeds Eight-Month Limit — R-100, RCA/RMA** Use to deny an RCA application or ongoing case because the household members entered the U.S. more than eight months ago. "You will not be eligible for TANF after mm/dd/yy." "La elegibilidad para Medicaid termina el mm/dd/yy."
097	**Filed In Error — No Notice** Use to deny a Notice of Application (NOA) that was created erroneously.
098	**Voluntary Withdrawal — A-100, Application Processing** Use only if an applicant requests that the application be withdrawn, or a current recipient requests that HHSC discontinue the case and the advisor cannot determine the reason. Otherwise use the applicable code. "You have advised us that you no longer want to apply for TANF." "Usted nos avisó que ya no desea solicitar TANF."

Code	Description
	"You have advised us that you no longer want to receive TANF." "Usted nos avisó que ya no desea recibir TANF."
099	**Other Miscellaneous — A-1000, Deprivation** • Use to deny TP 01 coverage for members who must be added to a TANF-SP case. "Your needs are now included in the TANF-SP case." "Ahora el caso de TANF-SP cubre sus necesidades." • Use to deny a case for other miscellaneous reasons. "You do not presently meet eligibility requirements." Usted presentemente no califica para asistencia."
134	**Refusal to Assign Child Support Rights — A-1100, Child Support** Use to deny an application or ongoing case because the caretaker's needs are removed for refusal to make assignment and income meets the needs of the remaining members. "You did not wish to assign support rights to the state." "No quiso usted conceder al estado el derecho de cobrar sostenimiento."
135	**Provide AP's Info or Location — A-1100, Child Support** Use to deny an application or an ongoing case because the caretaker's needs are removed for refusal to provide information on the absent parent or cooperate in locating the absent parent, and income meets the needs of the remaining members. "You did not supply information on the absent parent or assist support officer in locating the absent parent." "Usted no dio información sobre el padre o la madre ausente, o no ayudó al funcionario de manutención de niños a localizar a dicha persona."
136	**Provide Verification of Citizenship — A-350, Verification Requirements** Use to deny an application or ongoing case because all members in the certified group failed to provide verification of citizenship. "You did not provide proof of U.S. Citizenship." "Usted no presentó prueba de ciudadanía estadounidense."
137	**Refusal to Help to Establish Paternity — A-1100, Child Support** Use to deny a case because the caretaker's needs are removed for refusal to cooperate in establishing paternity and income meets needs of remaining members. "You chose not to help in establishing paternity." "No quiso usted ayudar a establecer la paternidad."
180	**Increased Earnings from Employment Services — A-1323.5, Wages, Salaries, Commission and Tips** Use to deny cases not eligible for post medical coverage if the denial results from employment or increased earnings within six months after participation in employment services. Also use to deny RCA cases because of failure to comply with employment/training requirements. "You are now ineligible due to increased earnings after employment services." "Usted no califica porque su salario aumentó después de su en el programa de servicios de empleo."
181	**Refusal to Comply With Employment Services, Caretaker — A-1800, Employment Services** Use to deny a case because the caretaker's needs are removed for failure to comply and income meets needs of remaining members. "You are now ineligible due to caretaker's refusal to register for employment services." "Usted no califica porque no quiso inscribirse en el programa de servicios de empleo."
196	**Failed to Sign the Responsibility Agreement — A-2100, Personal Responsibility Agreement** "Failure to sign the Responsibility Agreement." "Usted no firmó el Acuerdo de Responsabilidad Personal."
200	**Time Limit or Hardship Ends/Household Member Disqualified – A-2500, State Time Limits** "You are ineligible for TANF because _____'s needs were removed following time limit policies." "Usted no será elegible para TANF porque _____ dejó de ser elegible según las normas de los límites de tiempo."
201	**OT Ineligibility Period – A-2400, One Time Payments** "You are currently not eligible to receive TANF, OTTANF, or TANF-SP because you have received OTTANF during the past 12 months." "En este momento usted no es elegible para recibir TANF, OTTANF, ni TANF-SP porque usted ya recibió OTTANF que cubre los últimos 12 meses."
217	**Income Over 185% FPIL or No Earnings During the Fourth Month Transitional Reporting Period** "Your transitional Medicaid will be shortened to six months because you had no income or your gross earnings meet the needs that can be recognized by this agency." "Su Medicaid de transición se recortará a seis meses porque usted no tuvo ingresos o su salario bruto es suficiente para cubrir las necesidades que este departamento puede reconocer."
230	**Transitional Medicaid Expired at the End of the 12th Month — Computer Sent**

C-213 Reinvestigation Codes

Revision 02-8; Effective October 1, 2002

TANF

Select the code that best represents the reason for the case action. Enter it in Item 132, Form H1000-B, Record of Case Action, if taking action to raise, lower, sustain, or transfer a case to another type program.

Reasons for Raised Grants

Code	Description
101	"Your available income or resources are less." "Usted tiene ahora menos ingresos o recursos."
102	"Needs this agency can include in your check are more." "Ahora usted tiene más necesidades que esta agencia puede cubrir con su cheque."
103	"Your income and needs have changed." "Sus ingresos y sus necesidades cambiaron."

Reasons for Lowered Grants

Code	Description
104	"Your available income or resources have increased." "Usted tiene ahora másingresos o recursos."
105	"Needs this agency can include in your check are less." "Ahora usted tiene menos necesidades que esta agencia puede cubrir con su cheque."
106	"Your income and needs have changed." "Sus ingresos y sus necesidades cambiaron."

Reasons for Sustained Grants and Medical Assistance

Code	Description
107	"Needs included in your check remain the same." "Las necesidades cubiertas por su cheque no han cambiado."
108	"Changes in income and needs do not affect check." "Los cambios en sus ingresos y en sus necesidades no afectan su cheque."
109	"You are receiving the maximum assistance check." "Usted recibe la máxima cantidad de assistencia que se da."
110	"You remain eligible for medical coverage." "Usted sigue siendo elegible para beneficios médicos."

Reasons for Change in Assistance Status

Code	Description
111	Use when transferring from TP 01 or 61 to any income assistance medical program. "You are now eligible for medical coverage only." "Usted es elegible ahora sólo para beneficios médicos." Use when transferring from TP 01 or 61 to TP 40 to provide continuous coverage for a pregnant woman. "The pregnant woman on your TANF case is eligible for continuous medical coverage." "La mujer de su caso de TANF que está embarazada es elegible para cobertura médica continua."
112	Use when transferring from any income assistance medical program to TP 01 or 61. "You are eligible for financial and medical assistance." "Usted es elegible para beneficios médicos y asistencia financiera."

Reasons for Lowered Grants Because of Employment Services Program (ESP) Participation

Code	Description
115	"Earnings after ESP training have increased." "Las entradas aumentaron después de su entrenamiento para empleo."
116	"Adult's needs removed due to refusal to participate in employment services." "Las necesidades del adulto que se negó a participar en los servicios de empleo no pueden ser consideradas."

Transfers To and From Income Assistance Grant Programs

Code	Description
118	"Your family is now eligible for TANF-SP benefits only." "Ahora su familia es elegible solamente para beneficios de TANF-SP."
119	"Your family is now eligible for regular TANF benefits only." "Ahora su familia es elegible solamente para beneficios regulares de TANF."

Payee Change

Code	Description
120	Use when changing the payee from one designated relative to another relative when there is no break in assistance to the TANF children included in the case. "You will now receive the assistance payment." "Ahora va a recibir el cheque de asistencia a nombre de usted."

Transfers To and From Medical Programs for Families and Children

Code	Description
121	Use when transferring from any medical assistance program to another medical assistance program. This includes TP 07, 20, 29, 37, 40, 42, 43, 44, 45, 47, 48, and 55. "You have been transferred to another type of medical assistance." "Le cambiaron de una categoria del programa médico aotra." Use when transferring from any medical assistance program to TP 40 to allow continuous coverage for a pregnant woman. This includes TPs 07, 29, 37, 47 or an active TP 55 to TP 40. "The pregnant woman on your Medicaid case is eligible for continuous medical coverage." "La mujer de su caso de Medicaid que está embarazada es elegible para cobertura médica continua."

Reasons for Change in Transitional Medicaid Assistance Status

Code	Description
123	Use for TP 07 and TP 37 when • shortening transitional Medicaid to end after six months, or • restoring transitional Medicaid back to the original 12 months. "Your transitional Medicaid has changed because of the fourth-month Medicaid report." "Sus beneficios de transición de Medicaid han cambiado debido a su reporte para Medicaid del cuarto mes."

Reasons for Sustaining or Raising Benefits Because of Child Support

Code	Description
125	Removal of child's needs due to child support from absent parent, and income changes do not affect check. Use when removing a child's needs from the budget because of child support but other household income changes result in no grant change.
126	Sustained benefits. "Child support activities do not affect your TANF or Medicaid benefits." "Las actividades relacionadas con sostenimiento para niños no afectan sus beneficios de TANF ni de Medicaid."
127	Child's needs removed due to child support and your income has changed. Use when • removing the needs of a child receiving child support from an absent parent, but • raising the grant because other income has decreased.
128	Raised grant. "Your needs have increased and child support no longer exceeds the grant." "Sus necesidades han aumentado y el pago de sostenimiento para niños que recibe ya no sobrepasa la cantidad de la concesión."

Reasons for Lowering Benefits Because of Child Support

Code	Description
129	Child's needs removed due to child support received from absent parent. Use when lowering a grant because the needs of a child who is receiving child support from an absent parent are removed from the budget.
130	"You did not wish to assign support rights to the state." "No quiso usted conceder al estado el derecho de cobrar sostenimiento."
131	"You did not wish to supply information on absent parent." "No quiso usted dar informes acerca del padre/de la madre ausente."
132	"You chose not to cooperate with the child support officer." "No quiso usted colaborar con el encargado de los cobros de sostenimiento para niños."
133	"You chose not to assist in establishing paternity." "No quiso usted ayudar aaclarar la paternidad."
139	"Your grant has been reduced because a household member became eligible for SSI or SSA disability."

Reason or Message for Lowered Grant Because of Time Limits

Code	Description
138	Time Limit or Hardship Ends/Household Member Disqualified "Your grant was lowered because _____'s needs were removed following time-limit policies." "Se redujo su pago mensual porque _____ dejó de ser elegible según las normas de los límites de tiempo."

Reason/Message for Raised Grant Because of Time Limits

Code	Description
150	Time Limit or Hardship Ends/Household Member Disqualified "Your grant was raised. However, _____'s needs were removed following time-limit policies." "Se sebió su pago mensual. Sin embargo, _____ dejó de ser elegible según las normas de los límites de tiempo."

Reason/Message for Sustained Grant and Medical Assistance Because of Time Limits

Code	Description
160	Time Limit or Hardship Ends/Household Member Disqualified Use when sustaining TP 01 or 61. "Your grant remains the same. However, _____'s needs were removed following time-limit policies." "Su pago mensual seguirá igual. Sin embargo, _____ dejó de ser elegible según las normas de los límites de tiempo."

Reason or Message for Change in Assistance Status Because of Time Limits

Code	Description
170	Time Limit or Hardship Ends/Household Member Disqualified Use when transferring from TP 01 or 61 to any income assistance medical program. "You are eligible for medical assistance only. You are ineligible for a TANF grant because_____'s needs were removed following time-limit policies." "Usted es elegible para recibir solamente ayuda médica. Dejó de ser elegible para pagos mensuales de TANF porque _____ dejó de ser elegible según las normas de los límites de tiempo." When transferring to TP 29, also include the following message: "While receiving transitional Medicaid, you must report to HHSC within 10 days after you move and after anyone moves in or out of your household." "Mientras reciba Medicaid de transición, tiene que avisar a HHSC dentro de los 10 días de su cambio de casa o del cambio del número de personas de su casa."

C-220, Supplemental Nutrition Assistance Program Codes

Body

C-221 Denial Codes

Revision 12-1; Effective January 1, 2012

SNAP

Code	Description
601	**Excess Income, see C-242 for appropriate reference codes** "The amount of money you get each month is over the allowed amount." "La cantidad de dinero que recibe cada mes sobrepasa la cantidad límite."
602	**Excess Resources, see C-242 for appropriate reference codes** "The value of the things you own (resources) goes over the allowed amount." "El valor de las cosas de las que es dueño (recursos) sobrepasan la cantidad límite."
603	**Transferred Resources — A-1212** "You knowingly transferred resources to qualify for SNAP food benefits." "Transfirio sus recursos con la intención de recibir beneficios de comida del Programa SNAP."
604	**Death** No notice will be sent.
605	**Program Violation** No notice will be sent.
606	**Ineligible Students — A-200** "All members of your household are ineligible students." "Todos los miembros de su casa son estudiantes inelegibles."
607	**Refusal to Cooperate — C-920** "You refused to cooperate." "Usted se negó a cooperar."
608	**Voluntary Withdrawal — A-100** "You have advised us that you no longer wish to receive SNAP food benefits." "Nos dijo que ya no quiere recibir beneficios de comida del Programa SNAP."
609	**Failure to Provide Information — B-100 and C-900** "You did not provide enough information for this office to determine eligibility for SNAP food benefits." "No nos dio información suficiente para determinar si puede recibir beneficios de comida del Programa SNAP."
610	**Work Registration — A-1800** See Form H1017, Notice of Benefit Denial or Reduction, instructions for specific individual messages.
611	**Voluntary Quit — A-1800** "The household's primary wage earner voluntarily left his most recent job without good cause." "La persona que mantenia la casa dejó su empleo voluntariamente sin tener una razón aceptable."
612	**Unable to Locate — A-700** "You cannot be located at the address you gave us." "En la dirección que usted nos dió, no se le puede localizar."
613	**Moved from State —** No notice will be sent.
614	**Other, enter the appropriate reference** Indicate the specific reason.
615	**Missed Appointment — B-100** "You failed to keep your appointment after submitting an application for SNAP food benefits." "No se presento´ a la cita que le demos despues de presentar la solicitud de beneficios de comida del Programa SNAP."
616	**No Citizens or Eligible Aliens — A-300** "No member of the household is a U.S. citizen or an alien eligible for SNAP food benefits." "Ninguno de los miembros de su familia es ciudadano de los Estados Unidos o, elegible para recibir beneficios de comida del Programa SNAP."
617	**Application Filed in Error — No Notice** Use to deny a Notice of Application (NOA) that was created erroneously.
621	**Work Registrant Earnings — A-1323.5** "The amount of money you got from jobs (wages) goes over the allowed amount." "La cantidad de dinero que recibio de trabajos (salario) sobrepasa el limite establecido."
622	**Postponed Verification Not Provided – Expedited – A-145** "Your benefits were denied because you failed to provide the proof we requested when you were certified for expedited (emergency) services." "Esta negación de beneficios se debe a que usted nunca entregó las pruebas que se le pidieron cuando le declararon elegible para los beneficios de emergencia."
625	**State Office Use Only (SAVERR default code – open/close)** No notice.
626	**State Office Use Only (CCDMI/permanent move)** No notice.
627	**18-50 Denial — A-1900** "You have been disqualified for failing to meet the requirement for working 20 hours per week. To avoid the denial of benefits, you must begin working an average of 20 hours per week."

Code	Description
	"Usted ha sido descalificado por no satisfacer el requisito de trabajar 20 horas por semana. Para evitar la negación de beneficios, usted tiene que comenzar a trabajar un promedio de 20 horas por semana."
630	**State Office Use Only (Certification period expired)** No notice.

C-230, Medical Programs Codes

Body

C-231 Opening Codes

Revision 02-6; Effective July 1, 2002

Medical Programs

Code	Description
	TP 40 Use when providing continuous coverage for pregnant woman on TP 40 using Form H1000-A. "The pregnant woman in your household is eligible for continuous medical coverage." "La mujer de su caso de Medicaid que está embarazada es elegible par cobertura médica continua."
048	**TP 43, TP 44, TP 47 and TP 48** Use when providing continuous coverage for a child on TP 43, 44, 47, or 48. "The following people in your household are eligible for continuous medical coverage." "Las siguientes personas de su casa son elegibles para cobertura medica continua."
052	**TPs 40, 43, 44, 45, 48, and 55 without spend down** "Meets eligibility requirements." "Llena los requisitos de elegibilidad."
055	**TPs 40, 43, 44, 45, 48, and 55 without spend down** Use to reopen a case or application that was denied by mistake. "Denied in error." "Se negó por equivocación."
057	**TPs 40, 43, 44, 45, 48, and 55 without spend down** Use when opening a case instead of transferring from TP 01 or 61 in order to prevent the automated systems from counting a month(s) toward a individual's time limit. "Person(s) meet Medicaid eligibility requirements." "Persona(s) llena los requisitos de elegibilidad de Medicaid."

C-232 Denial Codes

Revision 09-3; Effective July 1, 2009

Medical Programs

Code	Description
059	**Death of Child (TPs 43, 45, 44, and 48) — A-500** "You no longer have children in your home who are eligible for assistance." "Ya no hay niños en su casa que califican para asistencia."

Earnings (TPs 43, 44, 47, 48, and 55)

Code	Description
060	**Earnings of Father — A-1323.5** "Earnings of father meet needs that can be recognized by this agency." "El padre gana suficiente para cubrir las necesidades reconocidas por esta agencia."
061	**Earnings of Mother — A-1323.5** "Earnings of mother meet needs that can be recognized by this agency." "La madre gana suficiente para cubrir las necesidades reconocidas por esta agencia."
062	**Earnings of Child – A-1323.1** "Earnings of child meet needs that can be recognized by this agency."

Code	Description
	"Su hijo/hija gana suficiente para cubrir las necesidades reconocidas por esta agencia."
	Earnings of Non-Parent Caretaker — A-1323.5
063	"Earnings of other person in your home meet needs that can be recognized by this agency." "Una persona que vive en su casa gana suficiente para cubrir las necesidades reconocidas por esta agencia."

Financial Support (TPs 43, 44, 47, 48, and 55)

Code	Description
	Support from Absent Father — A-1300
064	"Income from children's father who is outside the home meets needs that can be recognized by this agency." "El padre que no vive en la misma casa manda suficiente dinero para cubrir las necesidades reconocidas por esta agencia."
	Support from Relative in Household
065	"Income from relative in your household meets needs that can be recognized by this agency." "El dinero que recibe de un pariente que vive en su casa es suficiente dinero para cubrir las necesidades reconocidas por esta agencia."
	Support from Person Outside the Home
066	"Income available to you from a person outside the home meets needs that can be recognized by this agency." "El dinero que recibe de un pariente fuera de su casa es suficiente para cubrir las necesidades reconocidas por esta agencia."
	RSDI (TPs 40, 43, 44, 47, and 48) — A-1324.15
067	"Income available to you from social security benefit meets needs that can be recognized by this agency." "El cheque que usted recibe ahora, o va a recibir, del seguro social es suficiente para cubrir las necesidades reconocidas por esta agencia."
	Other Federal Benefits (TPs 43, 44, 47, 48, and 55) —A-1324.19
068	"Income available to you from Federal benefit or pension meets needs that can be recognized by this agency." "El dinero que usted recibe ahora de beneficios o pensiones Federales es suficiente para cubrir las necesidades reconocidas por esta agencia."
	State and Local Pensions or Benefits (TPs 43, 44, 47, 48, and 55) —A-1300
069	"Income available to you from state or local benefit or pension meets needs that can be recognized by this agency." "El dinero que usted recibe de beneficios o pensiones del gobierno local o del estado es suficiente para cubrir las necesidades reconocidas por esta agencia."
	Non-Governmental Pensions or Benefits (TPs 43, 44, 47, 48, and 55) —A-1326.9
070	"Income available to you from pension or benefit meets needs that can be recognized by this agency." "El dinero que recibe usted de pensiones o benficios es suficiente para cubrir las necesidades reconocidas por esta agencia."
	Excess Assets Income (TPs 40, 43, 44, 47, and 48) — A-13XX (See chart in C-241 for appropriate reference codes.)
	"Income available to you meets needs that can be recognized by this agency." "El dinero recibe ustedes suficiente para cubrir las necesidades reconocidas por esta agencia."
071	**(TPs 55 and 30) — A-13XX** (See chart in C-241 for appropriate reference codes.) "Income available to you exceeds the medically needy needs allowance and you have no medical expenses to spend down your income." "Usted dispone de ingresos que sobrepasan el limite para ser elegible para beneficios por necesidad médica y usted no tiene gastos médicos que se pudieran desontar de sus ingresos."
	Excess Assets — Resources (TPs 43, 44, 47, 48, and 55) — A-12XX (See chart in C-241 for appropriate reference codes.)
072	"Resources available to you from other property meets needs that can be recognized by this agency." "Los recursos que tiene usted en propiedades o dinero son suficientes para cubrir las necesidades reconocidas por esta agencia."
	Fewer Members in Certified Group (TPs 40, 43, 44, 47, 48, and 55) —A-1341
074	"No unmet need for the current family size." "Ahora, que usted tiene meno familia, sus entradas son suficientes para cubrir las necesidades reconocidas por esta agencia."
	Conflicting Information on Management (TPs 40, 43, 44, 47, 48, 55, and 30)— A-1700
075	"Information on management indicates additional income." "Según la información que tenemos, acerca de su situación económica, parece ser ue usted no reportó toda su entrada."
	Refusal to Furnish Information (TPs 40, 45, 43, 44, 47, 48, 55, and 30)— B-100
076	"You did not wish to furnish enough information for this agency to establish eligibility for assistance." "Usted no quiso darnos suficiente información para poder establecer su calificación para asistencia."
	Refusal to Follow Agreed Plan (TPs 40, 43, 44, 47, and 48) —A-1311
077	"You did not wish to follow agreed plan so that eligibility for assistance could be continued." "Usted ya no califica para asistencia porque no quiso utilizar, según el plan que hablamos, otros posibles recursos."

Code	Description
078	**Automatic Denial (TP 40)** Automatic denial because of anticipated pregnancy termination.
079	**Refusal to Obtain Medical Information for Pregnancy or Disability Determinations (TPs 40, 55, and 30) — A-800** "You did not wish to obtain required medical verification." "Usted no quiso obtener la verificación médica requerida."
080	**Parent Not Incapacitated (TPs 55 and 30) — A-1000** "You do not meet the agency's definition of incapacity." "Según la definición de 'incapacidad' de esta agencia, usted no califica."
082	**Legal Marriage (TPs 40 and 55)** "Your children are not deprived of parental support. The primary wage earner does not meet the employment or work history requirements." "A sus niños no les falta el sostenimineto paterno. El sostén principal de la casa no cumple con los requisitos con respecto a desempleo."
086	**Child Admitted to Institution (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — A-900** "Your child has been admitted to an institution." "Su niño ha sido admitido a un hospital u otra institución."
087	**No Eligible Child (TPs 40, 45, 43, 44, 47, 48, and 55) — A-900** "You no longer have children in your home who are eligible for assistance." "Usted ya no tiene niños en su casa que califican para asistencia."
088	**Residence (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — A-700** "Residence requirements are not met." "Sus niños no califican para asistencia porque no complen con el requisito de residencia en el estado."
089	**Citizenship or Acceptable Alien Status (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — A-300** "Citizenship or acceptable alien status requirements are not met." "No cumplen con los requisitos de ciudadanía ni de inmigrante elegible."
090	**Open/Close Coverage (TPs 40, 45, 43, 44, 47, 48, 55, and 30)** "Assistance was granted during a prior period, but you are not eligible now for medical assistance." "Usted calificó anteriormente para asistencia pero ahora ya no califica para beneficios médicos."
091	**Failure to Furnish Information (TPs 40, 45, 43, 44, 47, 48, 55, and 30)— B-100** "You failed to complete and return the necessary eligibility form." "Usted no ha entregado la form completa que necesitamos para determinar su elegibilidad."
092	**Other Eligibility Requirements (TPs 40, 45, 43, 44, 47, 48, 55, and 30)— A-100** Use for denying TP 45 because • the certified child becomes one year old, or • the child's mother is no longer eligible for Medicaid. "You do not meet eligibility requirements for assistance." "Usted no califica para asistencia."
094	**Appointment Not Kept (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — B-100** "You failed to keep your appointment." "Usted no vino a la cita que le dimos."
095	**Unable to Locate (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — A-700** "You cannot be located." "No lo podemos localizar a usted."
096	**Refugee Exceeds Eight-Month Limit (TP 55) — R-430**
097	**Filed In Error (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — No Notice** Use to deny a Notice of Application (NOA) that was created erroneously.
098	**Voluntary Withdrawal (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — A-100** "You have requested that your application for assistance be withdrawn." "Usted nos pidió que fuera retirada su solicitud osu concesión para asistencia."
099	**Other Miscellaneous (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — A-100** "You do not presently meet eligibility requirements." "Usted presentemente no califica para asistencia."
134	**TP 55 without spend down** "You did not wish to assign support rights to the state." "No quiso usted conceder al estado el derecho de cobrar sostenimineto."
135	**Provide AP's Info or Location — (A-1100)** Use to deny an application or an ongoing case because the caretaker's needs are removed for refusal to provide information on the absent parent or cooperate in locating the absent parent, and income meets the needs of the remaining members. "You did not supply information on the absent parent or assist support officer in locating the absent parent."

Code	Description
	"Usted no dio información sobre el padre o la madre ausente, o no ayudó al funcionario de manutención de niños a localizar a dicha persona."
136	**Provide Verification of Citizenship — (A-350)** Use to deny an application or ongoing case because all members in the certified group failed to provide verification of citizenship. "You did not provide proof of U.S. Citizenship." "Usted no presentó prueba de ciudadanía estadounidense."
137	**TP 55 without spend down** "You chose not assist in establishing paternity." "No quiso usted ayudar a establecer la paternidad."
195	**Monthly Income Exceeds Maximum Limits (TPs 40, 43, 44, 47, and 48)** "You are ineligible because your monthly income exceeds the needs recognized by this agency." "Usted no es elegible porque sus ingresos mensuales sobrepasan las necesidades reconocidas por esta agencia."

C-233 Reinvestigation Codes

Revision 01-7; Effective October 1, 2001

Medical Programs

Code	Description
110	**(TPs 40, 45, 43, 44, 47, 48, and 55 without spend down)** "You remain eligible for medical coverage." "Sigue siendo elegible para asistencia médica."
120	**(TPs 45, 43, 44, 47, 48, and 55 without spend down)** "You will now receive the medical coverage on behalf of the children." "Ahora usted va a recibir los beneficios médicos para sus hijos."

Use the following codes to clear Form H1708, Report of Noncooperation:

Code	Description
126	**(TPs 45, 43, 44, 47, 48, and 55 without spend down)** "Child support activities do not affect your TANF or Medicaid benefits." "Las actividades con respecto a sostenimiento para niños no afectan sus beneficios de TANF y los de Medicaid."
132	**(TPs 45, 43, 44, 47, 48, and 55 without spend down)** "You chose not to cooperate with the child support officer." "No quiso usted colaborar con el encargado de los cobros de sostenimiento para niños."

C-240, Expanded Denial Code Reference Charts

Body

C—241 TANF and Medical Programs Chart

Revision 02-3; Effective April 1, 2002

TANF and Medical Programs

Action Code	GWS Screen	New Reference	
060 Earnings of Father	Earned Income	A-1323.5	Wages, Salaries
061 Earnings of Mother	Earned Income	A-1323.5	Wages, Salaries
062 Earnings of TANF Child	Earned Income	A-1323.1	Earnings of Child
063 Earnings of Non-parent Caretaker	Earned Income	A-1323.5	Wages, Salaries

Action Code	GWS Screen	New Reference
064 Support from Absent Father	Contributions, Child Support, or Vendor Payments	A-1326.1 Gifts or Contributions A-1326.2 Child Support A-1334 Vendor Payments– Legally Obligated
066 Support from Other Person Outside the Home, Including Mother	Contributions or Vendor Payments	A-1326.1 Gifts or Contributions A-1334 Vendor Payments– Legally Obligated
067 RSDI	RSDI	A-1324.15 RSDI
068 Other Federal Benefits	VA	A-1324.19 VA Benefits
069 State and Local Pensions or Benefits	Retirements Workers' Compensation Unemployment	A-1326.9 Pensions A-1321.4 Workers' Compensation A-1324.18 Unemployment Benefits
070 Non-Governmental Benefits	Retirements	A-1326.9 Pensions
071 Income Not Codes 060 - 070 Excess Assets – Income	All Types of Countable Income	A-1324.17 Non-Generic TANF A-1326.1 Gifts or Contributions A-1326.2 Child Support A-1326.6 Interest – Bank Account A-1322.2 Unearned – WIOA A-1331 Lump Sum Income A-1326.9 Pensions A-1324.15 RSDI RR Retirement A-1326.9 Self Employment Income A-1323.4 Unemployment Benefits A-1324.18 Vendor Payments – Legally Obligated A-1334 VA Benefits A-1324.19 Wages, Salaries A-1323.5 Workers' Compensation A-1321.4 Other types of income which do not have a designated GWS screen. A-1310
072 Resources Excess Assets – Resources	All Countable Resources	A-1210 Cash-on-Hand, Stocks, Bonds, Bank Accounts A-1210 Land, Oil, and Mineral Rights, PASS Accounts A-1232.2 Prepaid Burial A-1242 Lump Sum Payments A-1231.4 Retirement – Pensions A-1238 Vehicles A-1200 Includes all other types of resources which do not have a designated GWS Screen.

C—242 SNAP Chart

Revision 01-7; Effective October 1, 2001

SNAP

Action Code	GWS Screen	New Reference	
601	Excess Income	Income – Earned or Unearned	A-1324.17 TANF Grant A-1326.1 Gifts or Contributions A-1326.2 Child Support A-1322.1 Educational Assistance – Non Title IV A-1326.6 Bank Accounts– Interest A-1322.2 Unearned – WIOA A-1331 Lump Sum Income A-1326.9 Pensions A-1324.15 RSDI A-1324.16 SSI A-1323.4 Self Employment A-1324.18 Unemployment Benefits A-1334 Vendor Payments– Legally Obligated A-1324.19 VA Benefits A-1323.5 Wages and Salaries A-1321.4 Workers' Compensation A-1310 Other income which does not have a designated GWS screen.
602	Excess Resources	Resources – Countable	A-1210 Cash-on-Hand, Stocks, Bonds, Bank Accounts A-1210 Land, Oil, and Mineral Rights A-1242 Lump Sum Payments A-1236.4 Real Property A-1231.4 Retirement Accounts A-1238 Vehicles A-1200 Other resources not listed in this section because they do not have a designated GWS screen.

C-300, County Charts

C-310, Full and Minimum Service Choices Counties by Region

Body

Revision 12-3; Effective July 1, 2012

TANF

The following is a list of full and minimum service Choices counties.

Region	Full Service Counties	Minimum Service Counties
Region 1	Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, Yoakum	King
Region 2	Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Fisher, Foard, Hardeman, Haskell, Jack, Jones, Knox, Mitchell, Montague, Nolan, Runnels, Scurry, Shackelford, Stephens, Stonewall, Taylor, Throckmorton, Wichita, Wilbarger, Young	Kent

Region	Full Service Counties	Minimum Service Counties
Region 3	Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise	Not applicable
Region 4	Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt , Wood	Not applicable
Region 5	Angelina, Hardin, Houston, Jasper, Jefferson, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler	Not applicable
Region 6	Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton	Not applicable
Region 7	Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington, Williamson	Not applicable
Region 8	Atascosa, Bandera, Bexar, Calhoun, Comal, DeWitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, LaSalle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, Zavala	Not applicable
Region 9	Andrews, Coke, Concho, Crane, Crockett, Dawson, Ector, Gaines, Glasscock, Howard, Irion, Kimble, Martin, Mason, McCulloch, Menard, Midland, Pecos, Reagan, Reeves, Schleicher, Sterling, Sutton, Terrell, Tom Green, Upton, Ward, Winkler	Borden, Loving
Region 10	Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Presidio	Not applicable
Region 11	Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, Zapata	Not applicable

C-320, TANF State Time Limit County Hardship Lists

Body

C-321 Current TANF State Time Limit County Hardship List

Revision 26-3; Effective July 1, 2026

TANF

Benefits Issued for January 2026 Through March 2026

Region	County	County Code
11	Starr	214

C-322 Previous TANF State Time Limit County Hardship Lists

Revision 26-3; Effective July 1, 2026

TANF

Benefits Issued for October 2025 Through December-2025

Region	County	County Code
11	Starr	214

Benefits Issued for July 2025 Through September 2025

Region	County	County Code
11	Starr	214

Benefits Issued for April 2025 Through June 2025

Region	County	County Code
None	None	None

C-330, SNAP ABAWD Work Requirement Waiver Counties

Body

C—331 Current SNAP ABAWD Work Requirement Waiver Counties

Revision 22-4; Effective Oct. 1, 2022

SNAP

Effective October 2022		
Region	**County**	**County Code**
None	None	None

C—332 Previous SNAP ABAWD Work Requirement Waiver Counties

Revision 22-4; Effective Oct. 1, 2022

SNAP

Effective October 2021		
Region	**County**	**County Code**
None	None	None

C-340, SNAP Employment and Training Counties

Body

Revision 18-4; Effective October 1, 2018

Region	SNAP Employment and Training Counties
Region 1: High Plains	Bailey, Castro, Childress, Deaf Smith, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Moore, Ochiltree, Potter, Randall, Terry
Region 2: Northwest Texas	Archer, Baylor, Brown, Clay, Coleman, Comanche, Cottle, Eastland, Foard, Hardeman, Haskell, Jack, Mitchell, Montague, Nolan, Runnels, Scurry, Stephens, Taylor, Wichita, Wilbarger, Young
Region 3: Metroplex	Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Jones, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise
Region 4: Upper East Texas	Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, Wood
Region 5: Southeast Texas	Angelina, Hardin, Houston, Jasper, Jefferson, Nacogdoches, Orange, Polk, Sabine, San Jacinto, Shelby, Trinity, Tyler
Region 6: Gulf Coast	Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton
Region 7: Central Texas	Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Llano, Madison, McLennan, Milam, Robertson, San Saba, Travis, Washington, Williamson
Region 8: Upper South Texas	Atascosa, Bandera, Bexar, Calhoun, Comal, DeWitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, LaSalle, Lavaca, Limestone, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, Zavala
Region 9: West Texas	Coke, Concho, Crockett, Dawson, Ector, Howard, Irion, Kimble, Mason, McCulloch, Menard, Midland, Pecos, Reagan, Reeves, Schleicher, Sterling, Sutton, Tom Green, Ward
Region 10: Upper Rio Grande	Brewster, Culberson, El Paso, Presidio
Region 11: Lower South Texas	Aransas, Bee, Brooks, Cameron, Hidalgo, Jim Hogg, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, Zapata

C—341 SNAP Non-Employment and Training Counties

Revision 22-4; Effective Oct. 1, 2022

Region	SNAP Non-Employment and Training Counties
Region 1: High Plains	Armstrong, Briscoe, Carson, Cochran, Collingsworth, Crosby, Dallam, Dickens, Donley, Floyd, Gray, Hall, Hansford, Hartley, Hemphill, King, Lipscomb, Lynn, Motley, Oldham, Parmer, Roberts, Sherman, Swisher, Wheeler, Yoakum
Region 2: Northwest Texas	Callahan, Fisher, Kent, Knox, Shackelford, Stonewall, Throckmorton
Region 4: Upper East Texas	*None*
Region 5: Southeast Texas	Newton, San Augustine
Region 7: Central Texas	Mills
Region 9: West Texas	Andrews, Borden, Crane, Gaines, Glasscock, Loving, Martin, Terrell, Upton, Winkler
Region 10: Upper Rio Grande	Hudspeth, Jeff Davis
Region 11: Lower South Texas	Duval, Kenedy, Live Oak, McMullen

C-350, County Lists

Body

Revision 12-2; Effective April 1, 2012

All Programs

- Alphabetical County Names, Codes and Regions

C-400, Reserved for Future Use

C-500, Form H1000-A, Form H1000-B and Form H1000-C Instructions (Retired as of July 1, 2013)

C-510, General Information

Body

Revision 05-4; Effective August 1, 2005

General Information

All Programs

Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action, and Form H1000-C, Secondary Client Input, are manual forms used in all programs to report applications, the subsequent denial or certification of eligibility, and changes and deletions to information for certified and denied cases. Use a separate Form H1000-A, Form H1000-B or Form H1000-C to report actions taken in each individual program.

Form H1000-A is a four-part form. Each part has the same control number.

- Part 1, Notice of Application (NOA) is a short form that
  - indicates that an application was filed and the date filed, and
  - gives information for an NOA report to field staff about individual information already in the computer file.
- Part 2, Input Document, is a page advisors use for handwritten entries during the decision process. Use the input document to
  - report the final disposition of an application,
  - correct Items 01 through 38 already sent on the NOA,
  - authorize the issuance of benefits, or
  - establish a central file on all individual data.

- Part 3, Case Record Copy, is a carbon copy of Part 2. It contains information on the NOA and the disposition of an application for audits.
- Part 4, Case Index Card, is a carbon copy of the NOA used to
  - make a central file of pending applications in the local office, and
  - report changes on pending applications.

Form H1000-B is a three-part form. The assigned case number and sequence number appears on all copies of the form. To request Form H1000-B, use Form H1004, Request for Form H1000-B.

- Part 1, Record of Case Action, is a computer-generated form that shows current case information.
- Use the Part 2, Input Document, to
  - update information;
  - report the disposition of a redetermination; or
  - authorize, adjust, or cancel benefits.
- Part 3, Case Record Copy, is identical to Part 2, Input Document. All items entered on the input document appear on the Case Record Copy.

Form H1000-C is a one-part form. Use this form to enter

- start and end dates for PRA penalties and good cause,
- finger image code and vun, and
- disqualifications and Supplemental Nutrition Assistance Program (SNAP) work requirement countable months.

Advisors must submit Form H1000-A or Form H1000-B with Form H1000-C.

C—511 Form H1000-A

Revision 05-4; Effective August 1, 2005

All Programs

Correct any errors made on Part I, Notice of Application (NOA), before submitting the form for processing.

You must process the NOA before entering the input document information. Batch and submit the NOA before, or on the same day as, the input document.

If staff damage or lose Form H1000-A, Notice of Application, substitute the same form from another set. Block out the preprinted application number and enter the application number of the original NOA.

If the number of applicants listed on Form H1010-B, Application for Assistance - Part B: Information We Need to Know, exceeds 11 people, complete an additional set of forms. Complete Item 04, Page, on the first NOA. Block out the preprinted application number on the additional NOA forms and enter the original application number of the first NOA. Make entries in

Item 04, Page;
Item 06, Budgeted Job Number;
Item 07, Mail Code;
Item 09, Case Name; and
Items 33-38. Make sure to begin with line "b" in Items 33-38.

Staple the NOAs together and batch as one.

When an applicant moves and the move requires the transfer of a pending application to another office, forward all material, including Form H1031, Case Record Transfer. The receiving office is responsible for updating the new budgeted job number, mail code, and county number.

C—512 Form H1000-B

Revision 02-3; Effective April 1, 2002

All Programs

The Form H1000-B, Record of Case Action, input document is identical to the Form H1000-A, Notice of Application input document. The following items appear on the record of case action, input document, and case record copy:

Item 01, Case number;
Item 02, Category;
Item 03, Sequence;
Item 09, Case name; and
Item 32, Client number.

Enter changes in the case information in red ink. To report a change or correction:

- circle the section number.
- circle the individual line indicator in the section where the change is entered. If a change is made in Section III only, circle the individual line indicator in both Sections II and III.
- enter the new information.
- enter the client number in Item 50, Client Number Validation, if changing the name and date of birth of the same client.

You may not change:

Item 08, Date Filed;
Item 32, Client Number;
Item 37, Social Security Number (SSN) validated with an asterisk;
Item 38, Social Security Claim Number validated with acode 1 or 3;
Item 48, PA – Refugee; and
Item 129, Grant Effective Date(TANF only).

Additionally for TANF Medicaid Programs you may not change

Item 02, Category; and
Item 46, Medical Effective Date (over six months old).

To delete income amounts and social security account numbers without asterisks (Item 37), enter a zero in the item. Delete all other information (including the social security claim number, Item 38) by entering a pound sign (#) in the first position of the item. Do not use a pound sign as an abbreviation for number.

To delete an individual name and individual information, enter a pound sign in Item 33, Client Name. If deleting a TANF or Medical Programs individual due to death, re-enter the original status-in-group code for the deceased individual plus status-in-group code X in Item 40, Status in Group. Enter the individual's date of death in Item 47, Death/Denial Date.

If you delete a

- TANF certified member, adjust the total needs amount in Item 66.
- Medical Programs budget group member, adjust the total needs amount in Item 66, and the number of adults/children included in the budget group in Items 125, and 126.

C-520, Form H1000-A and Form H1000-B Completion Instructions

Body

C—520.1 Section I, Items 01 - 31

Revision 02-3; Effective April 1, 2002

All Programs

Items 01 through 39 are listed on the Notice of Application. On the NOA, complete all items except Items 32 and 39. Items 02, 06, 07, 08, 09, 13, 15, 16, 17 and 25 cannot be deleted, but may be updated.

ITEM 01: Case Number

All Programs

If known, enter the previously assigned case number. To reassign a number, ensure that the case name is identical to the name as it appeared at the time of denial. The reassigned case number must have been active within the past year for non-public assistance (PA) Supplemental Nutrition Assistance Program (SNAP) and within the past two years for PA SNAP, TANF and Medical Programs for Families and Children.

ITEM 02: Category

TANF and Medical Programs

On the NOA, enter the code in the left-hand box that describes the type of assistance. Enter changes or corrections in the right-hand box.

2 — TANF/Medical Programs

5 — Refugee Cash Assistance (RCA)

SNAP

On the NOA, enter the code in the left-hand box that describes the type of assistance. Enter changes or corrections in the right-hand box.

6 — PA SNAP

8 — All members are refugees, other than Cuban/Haitian entrants, receiving TANF or RCA (Aid Type 5)

9 — Non-PA SNAP

ITEM 03: Sequence No. (SEQ)

All Programs

For a TANF/Medical Programs NOA, enter code Y if the case name received TANF/Medical Programs within the past two years.

The sequence is computer-printed on 1000-B turnaround. The initial Form H1000-B from the Form H1000-A input document is always sequence 02. Use only the most current sequence to update information. The sequence number cannot exceed the number 99. After 99 the sequence begins at 02 again.

ITEM 04: Page

All Programs

If more than one form is required, enter the page number in the first space and the total number of pages in the second space.

ITEM 05: Print Date

All Programs

Computer printed on 1000-B turnaround. This is the date the information from the input form is entered into SAVERR.

ITEM 06: Budgeted Job Number

All Programs

Enter the first eight alphanumeric characters of the budget job number assigned to the application.

ITEM 07: Mail Code

All Programs

Enter the mail code of the budgeted job number assigned to the application.

ITEM 08: Date Filed

All Programs

Enter the file date of application for assistance. Use month, day, year sequence.

Note: When adding a child to a new program, the file date is the date of the reported change.

SNAP

Also enter the date on the SNAP Form H1000-B, Record Of Case Action, when a new Form H1010-B, Application for Assistance - Part B: Information We Need to Know, is received.

Medical Programs

For reopened three months prior applications, enter the date the applicant requests the application be reopened. Enter the month and year of the original file date in Item 134, Three Months Prior Application Date.

ITEM 09: Case Name

All Programs

Enter on the NOA the individual's last name, comma, first name, space, middle name, or initial until the name is complete or the maximum of 22 positions is reached. The 22 positions include alphanumeric characters, commas, and spaces. If the last name includes Jr, Sr, etc., enter this after the last name(**Example:** SmithJr,Robert).

ITEM 10: Case Name Change

All Programs

To report a change or correction in case name, enter the complete name in the 22 positions provided in the format described in Item 9, Case Name. If the case name is on a line other than "a," Section II, of the NOA, enter

- the correct name in Item 10; and
- a pound sign (#) on line "a" of Section II, Item 33, Client Name, if you are removing the person reported on line "a."

If the person reported on line "a" remains a part of the ...	then enter the appropriate status-in-group code ...
TANF case,	for this person on line "a" of Section III, Item 40, Status-in-Group, and the appropriate entry in Item 41, ESP Code.
SNAP case,	if any, or a pound sign in Item 40, Status-in-Group to delete a code that is no longer applicable.
Medical Programs case,	for this person on line "a" of Section III, Item 40, Status-in-Group.

If the new case name is not reported on the NOA, add the person's name and information on the first available line of Section II, Item 33, Client Name. Enter the appropriate codes in Item 40 for all programs and in Item 41 for TANF and SNAP on the line where the new case name is listed.

The computer automatically realigns names to ensure the correct name is on line "a." Do not attempt to move names from line to line on Form H1000-A or Form H1000-B.

ITEM 11: Reserved

ITEM 12: Employee Number

All Programs

Enter the employee number of staff assigned the application.

ITEM 13: Mailing Address, First Line

All Programs

Enter the street number and name, rural free delivery, or post office box number using these abbreviations:

Ave — Avenue

Blvd — Boulevard

Cir — Circle

CT — Court

Dr — Drive

Gen Del — General Delivery

Hwy — Highway

Ln — Lane

PO Box — Post Office Box

Rd — Road

RFD — Rural Free Delivery

RR — Rural Route

St — Street

Do not use a pound sign (#) as a part of an address. See example in B-222.1, Mailing Addresses for Issuing Benefits, for cases with P.O. Box addresses.

TANF

When a TANF case has a guardian or protective payee, use their mailing address in Items 13-17.

ITEM 14: Mailing Address, Second Line

All Programs

Use this space if additional lines are required for the mailing address.

ITEM 15: City

All Programs

Enter the name of the city or town used in the mailing address.

ITEM 16: State

All Programs

Enter the two-letter postal abbreviation of the state used in the mailing address. Allowed abbreviations are:

TX — Texas

AR — Arkansas

LA — Louisiana

NM — New Mexico

OK — Oklahoma

ITEM 17: ZIP Code

All Programs

Enter the ZIP code of the mailing address.

ITEMS 18 - 24 ARE NOT PRINTED ON THE NOA.

TANF and Medical Programs

Use Items 18-23 to mail Form H3087, Medicaid Identification, to a temporary address. To change any of these items on a Form H1000-B, Record of Case Action, input document, re-enter all items. Use a pound sign (#) to delete items.

ITEM 18: Temporary Address, First Line

TANF and Medical Programs

Enter the temporary mailing address.

ITEM 19: Temporary Address, Second Line

TANF and Medical Programs

Use this space if additional lines are required for the temporary address.

ITEM 20: Temporary Address, City

TANF and Medical Programs

Enter the name of the city or town.

ITEM 21: State

TANF and Medical Programs

Enter the two-digit postal abbreviation of the state.

ITEM 22: ZIP Code

TANF and Medical Programs

Enter the ZIP code.

ITEM 23: Temporary Address; Months; Begin Month

TANF and Medical Programs

Months: Enter the number of months, not to exceed three, that Form H3087, Medicaid Identification, is to be sent to a temporary address.

Begin Month: Enter the month the temporary address becomes effective.

ITEM 24: Residence Address

All Programs

Enter the residence address, street, and city only if different from the mailing address. Always enter the entire address.

TANF and TP 40

Enter the telephone number, if provided, for an application from a pregnant woman.

ITEM 25: County

All Programs

Enter the three-digit code for the county associated with advisor's BJN.

Note: For TANF and Medical Programs, enter the individual's residence code in Item 164. See C-350 for the county codes.

Items 26 – 27 are not printed on the NOA.

ITEM 26: Protective Payee (TANF/Medical Programs); Authorized Representative (FS)

Enter the last name, comma, first name, space, middle name or initial until the name is complete or the maximum of 22 positions is reached. Enter the name of the institution in usual word order omitting commas, if the guardian is an institution (such as, First National Bank), or the representative payee is a licensed residential child care facility. The 22 positions include alphanumeric characters, comma, and space. If staff make an entry in this item, they must also make an entry in Item 27, Modifier.

TANF and Medical Programs

Enter the name of the legal guardian (exactly as shown on guardianship papers), protective payee, or representative payee.

SNAP

Enter the name of the authorized representative. If the authorized representative is an institution such as a halfway house, enter the name of the employee designated by the institution to act as authorized representative on its behalf.

ITEM 27: Modifier (M)

All Programs

Enter the code that identifies the person listed in Item 26.

TANF and Medical Programs

P — Protective Payee

Note: Also use P for those cases in which a representative payee is designated to receive and manage the benefits for an individual who is incompetent or incapacitated.

R — Representative Payee

SNAP

I — Authorized representative is a member of household (under the same roof).

O — Authorized representative is not a member of household (not under the same roof).

F — Authorized representative is an employee of a drug and alcohol treatment/group living arrangement facility.

ITEM 28: Indicator (I) Code

TANF

Enter on NOA. Enter only changes or corrections on Form H1000-A, Form H1000-B and Form H1000-C.

For TANF, enter code M in this item if potential eligibility is based on an incapacity determination.

For TANF-SP, make no entry. SAVERR prints U when TP 61 transfers to TP 07, 20, or 37.

SNAP

1 — Streamlined reporting (SR) household with total gross monthly income that is less than or equal to 130% FPIL.

2 — SR household with total gross monthly income that is greater than 130% FPIL.

3 — Non-SR household.

ITEM 29: Action Notice (MMDDYY)

All Programs

On Form H1000-A/B, enter the date you give the individual Form H1017, Notice of Benefit Denial or Reduction. This entry is mandatory for all denials except for Application Filed in Error, denials. For Medical Program individuals, enter the date you give the individual Form H1122, Medicaid Action Notice.

ITEM 30: Medical Delay

Medical Programs

Use for emergency medical conditions. Make an entry, using four alphanumeric characters, when more than 10 days elapse between giving/mailing a request for medical information and the date the local office receives the information. Enter code E and the number of days over 10. **Example:** E015.

TANF

Use when a TANF applicant applies in pay for performance and must demonstrate cooperation. A period of up to 40 days is excluded from the timeliness calculation. Enter Code E and the number of days after the interview date needed to demonstrate cooperation. **Example:** E030. Do not allow more than 40 days.

ITEM 31: Medical Programs Application Indicator

Medical Programs

Make an entry only on the NOA. Enter

- W to identify a TP 40 application or TANF application with a pregnant woman; or
- Y to distinguish Medical Programs applications from other Category 02 applications. Do not enter on Form H1000-B.

C—520.2 Section II, Items 32 - 39

Revision 10-4; Effective October 1, 2010

All Programs

This section contains identifying information for each person listed on the form. Always use line "a" to enter information about the head of household (case name). Items 32, 33, 34, 35, 36, and 39 cannot be deleted, but may be updated.

ITEM 32: Client Number

All Programs

When certifying a case, for each person listed in Section II, enter

- the nine-digit individual number or
- Code 2. This code tells SAVERR to check for an existing client number. If a number exists, SAVERR will reassign the client number. If a number does not exist, SAVERR will assign a number.

If Form H1000-A, Notice of Application, or Form H1000-B, Record of Case Action, will not process because of error message 307, "client is already active in same program on another case," research the case to determine if the individual is currently active in another case in the same program.

If the individual is ...	then ...
not currently active in the same program or is entitled to dual SNAP participation as a resident of a shelter for battered persons,	follow procedures in B-454.1, Duplicate Participation Procedures.
currently active in the same program and is not entitled to dual benefits,	take appropriate action to prevent duplicate participation. Process an overpayment, if applicable. The advisor who discovers duplicate participation is responsible for notifying the other offices involved.

SAVERR does not assign a client number on denied initial applications.

See C-800, Automated Support Systems, for individual merge/separate information.

To reassign a client number without an entry in Item 50, Client Number Validation, enter Code 2 in Item 32 and the person's name, birth date, social security account number, and social security claim number so that they match the information already in the computer file.

To correct biographical information enter:

- up to three corrections on the input document. Ensure that at least one item matches the information already on file.
- the client number in Item 32 and Item 50, Client Number Validation.

Using Item 50 allows the client number to be reassigned, but hierarchy may still prevent using the biographical data.

ITEM 33: Client Name

All Programs

Enter the name(s) of the people listed on Form H1010-B. Type the last name, comma, first name, space, middle name or initial until the name is complete or you reach the maximum 22 positions. The 22 positions include alphanumeric characters, comma, and spaces.

The only spaces allowed are after the first name. Do not use spaces within a last or first name. If the name includes a Jr., Sr., II, III, etc., it must follow the last name. **Example:** SmithJr, John Z. Enter the individual's name from line a in Item 09, Case Name, instead of Item 33.

Some eligible non-U.S. citizens traditionally use a name order that is different from the customary U.S. order (first name, middle name, last or family name). Advisors should determine name order according to U.S. custom, and enter it appropriately on Form H1000-A and Form

H1000-B. **Example:** Vietnamese name on I-94: Nguyen(last) Thi(first) Mai(middle) Enter on Form H1000-Aand Form H1000-B: Nguyen,Thi Mai.

Medical Programs

Enter the names of all persons in the budget group. This group includes all the eligible and ineligible people whose needs, income, resources, and medical expenses are used to determine eligibility and/or spend down.

ITEM 34: Birth Date

All Programs

Enter the birth date for each person listed.

ITEM 35: Sex

All Programs

Enter the sex for each person listed.

M — Male

F — Female

ITEM 36: Race

All Programs

Enter the code that describes the race, color, national origin for each person listed:

1 — White (not Hispanic) – People whose origins derive from the original people of Europe, North Africa, or the Middle East.

2 — Black (not Hispanic) – People whose origins derive from the black racial groups of Africa.

3 — Hispanic – People of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

4 — American Indian or Alaskan Native – People whose origins derive from the original people of North America.

5 — Asian or Pacific Islander – People whose origins derive from the original people of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes China, Japan, Korea, the Philippine Islands, and Samoa.

6 — State Office Use Only – A code entered by the computer if the worker makes no entry or enters an inappropriate code. Staff must take action to correct.

ITEM 37: Social Security Number (SSN)

All Programs

Enter the social security number (SSN) for each person listed. Following the nine-digit entry is a space used to indicate the verification status of the SSN. A computer printed asterisk (*) indicates Social Security Administration verified the SSN. A verified SSN cannot be changed on Form H1000-B and Form H1000-C. If you determine the number is incorrect, send a memorandum with the correct SSN to State Office Data Integrity (SODI), to make a change:

SODI Section, Data Base Support Unit
P.O. Box 14930, MC Y92-2
Austin, TX 78714-9030

Or fax to the Data Base Support Unit at 512-706-7140.

SODI Section notifies the staff by memo when the change is made.

A blank space following the SSN indicates the SSN was entered by the advisor but is not verified.

ITEM 38: Social Security Claim Number

All Programs

Enter the benefit claim number for people enrolled in Medicare or for people who receive social security or Railroad Retirement (RR) benefits. If a person is receiving benefits under more than one number, use the number shown on the Medicare card. If there is no claim number assigned, leave blank.

Note: If entering a RR benefit claim number in Item 38, total the household's RR benefits in Item 55, not in Item 43.

Following the claim number is a code indicating whether the state is paying Medicare premiums for the individual or the individual has private medical insurance. The codes apply to all cases, but are not printed on the SNAP Form H1000-B and Form H1000-C. Reports that include biographical information have these codes. They are

0 — No insurance.

1 — Medicare premium paid by state.

2 — Private medical insurance.

3 — Private medical insurance and Medicare premium paid by state.

The presence of a code 1 or 3 indicates SSA validated the number and the number cannot be changed on Form H1000-B and Form H1000-C. If you determine a verified number is incorrect, send a memorandum with the correct number to Data Control Section, Special Programs Support Unit, State Office, Y-922, to make a change.

THIS COMPLETES THE ALLOWABLE ENTRIES ON THE NOTICE OF APPLICATION.

ITEM 39: Education/Service Code

TANF

Enter an education code for each person in the certified group who is 16 or older (including a child who will be 16 during the month of certification). Note: Do not change the code unless it was incorrect at the time the initial tier level was set or the individual has been denied for at least one complete month before reapplying.

SNAP

Enter an education code for each person with a Code 2, 3, 4, R, V, W, X, or Y in Item 41, Work Registration. **Note:** Education codes entered for TANF individuals will be printed on the next Form H1000-B that processes, whether registered for SNAP ESP or not.

TANF and SNAP

Enter a code in the first digit of Item 39 to indicate the highest educational level/grade each person has completed. Do not consider vocational/technical schools when determining education level.

Educational Level	Code
1st grade	1
2nd grade	2
3rd grade	3
4th grade	4
5th grade	5
6th grade	6
7th grade	7
8th grade	8
9th grade	9
10th grade	A
11th grade	B
High school graduate/completed general equivalency diploma	C
Attending college or completed some college but has not graduated from a four-year college	E
Graduate of a four-year college	F
No formal education	N

C—520.3 Section III, Items 40 - 50

Revision 11-3; Effective July 1, 2011

All Programs

Section III (a-k) is an extension of Section II (a-k). Each line in Section III relates to the corresponding line in Section II and is used to provide additional information about the people listed. Example: The status-in-group code for the case name in Section II, line **a**, is reported in Section III, line **a**. Items 40 and 46 for Temporary Assistance for Needy Families (TANF) and Medical Programs, and Item 41, for TANF and the Supplemental Nutrition Assistance Program (SNAP), cannot be deleted but may be updated.

If an active case is denied, all monetary amounts for the case are kept in the System for Applications, Verifications, Eligibility Reports and Referral (SAVERR) files until the case is purged. The amounts kept in SAVERR files are those budgeted for the latest month of eligibility.

The same is true for individual income amounts. The amount shown, however, is the latest amount of income budgeted in any program. If the individual is moved to another case, the individual income amounts can be updated. Staff can change individual income amounts if denying an active case. This action does not update the TANF case income but does update the SNAP case income.

TANF and Medical Programs

When a certified recipient becomes a payee or case name, medical effective date is automatically deleted. For TANF, the ESP code is also deleted.

ITEM 40: Status-in-Group

All Programs

Status-in-group (SIG) codes identify the people's relationship to the case. Enter all codes that describe the people listed on Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action and Form H1000-C, Secondary Client Input. A maximum of six codes may be used for one person.

TANF and Medical Programs

Assign each person listed one primary code. Use secondary codes only in combination with a primary code. Use secondary codes when required or to provide additional information. **Note:** For TP 30 case, include only one person with an eligible primary code (SIG 8 or 4) per case.

SNAP

Always enter a code to identify the head of household. Use other codes when appropriate. Use the head of household codes with any of the other codes listed under other codes. Only one person in the case, however, may be given a code indicating head of household.

TANF

Primary Codes

2 – Disqualified/Ineligible Child or Second Parent— Identifies a child or second parent who would be a required member of the certified group but who is disqualified or ineligible for another reason, including noncompliance with the unmarried minor parent domicile requirement.

3 – Noncertified child – Identifies the only deprived child of the certified caretaker/second parent.

If the child receives ...	then enter SIG Code ...
SSI	3
Foster Care Payments	3F
Adoption Assistance payments	3A

5 – Certified Child – Identifies a child included in the certified group for TANF or refugee cash assistance (RCA) cases.

7 – Second Parent — Identifies the second parent in a TANF-SP case.

Do not use Code 7 for a Supplemental Security Income (SSI) recipient, to identify the case name, or for more than one member.

8 – Caretaker — Identifies the caretaker in TANF cases.

Do not use Code 8 for an SSI recipient or for more than one member.

9 – Payee – TANF payee only includes:

- SSI recipients (legal parents and other caretaker relatives), or

- other caretaker relatives who act as head of the TANF household and who are not eligible for TANF or do not want to be included as a caretaker (See A-222, Who is Not Included).

0 – Case Name Only — Identifies a legal parent disqualified for:

- intentional program violation;
- alien status/citizenship requirements;
- failure to comply with employment services, child support, SSN or third-party resource (TPR) requirements;
- failure to timely report the temporary absence of a certified child;
- being a fugitive;
- noncompliance with the unmarried minor parent domicile requirement; or
- a felony drug conviction (not deferred adjudication) for an offense committed on or after April 1, 2002. This disqualification is permanent. See A-222, Who is Not Included.

Secondary Codes

E – Federally Recognized Tribe or Unaccompanied Refugee Minor(URM) — Identifies individuals who are either members of a federally recognized Indian tribe or a URM. These individuals are exempt from mandatory enrollment in Medicaid managed care.

G – Reached End of State Time Limit — Identifies a person who used the maximum number of TANF months in a time limit and has a five year freeze out date on SAVERR. This code can be used with all primary SIG codes.

H – Eligible Refugee — Identifies a person identified as an eligible Amerasian, refugee, asylee, victim of severe trafficking or Cuban/Haitian entrant by the U.S. Citizenship and Immigration Services (USCIS) on Form I-94 or other USCIS document. Continue using Code H until the individual has resided in the U.S. for five years. Code H may be combined with any primary codes. **Note:** Entry of Code H requires an entry in Item 48.

I – Ineligible Child – Identifies a child who is ineligible for TANF for a reason other than being disqualified or being an SSI recipient. Use Code I only with Code 2.

K – Child of a Minor Child – Identifies the child of a minor parent who is also included in the TANF grant. Use Code K only with Code 5.

L – Minor Parent with a Dependent Child – Identifies a minor parent who has a dependent child on the same case. Use Code L with Codes 5, 7, 8, 9 or 0.

M – Eligible Only for Three Months Prior Medical Assistance— Identifies a person who is eligible for medical assistance during any or all of the three months before the month of application, but who is not currently eligible for medical assistance. Use Code M with Codes 5, 7 or 8.

N – Ineligible for Retroactive Medical Assistance and Current Assistance — Identifies a member of the dependent group who must be reported to certify a case for three months prior Medicaid coverage. Use this code for a member of the dependent group who is ineligible for retroactive medical assistance and current assistance. Use Code N with Codes 5, 7 or 8 to identify members of an OTTANF case. **Note:** If all people in a case are status-in-group N, the case must be Type Programs 11, 71 or 72.

O – Department of State Health Services (DSHS) Child with Special Health Care Needs— Identifies a child who is exempt from mandatory enrollment in Medicaid managed care.

P – Private Health Insurance — Identifies a certified person who has private health insurance other than Medicare or Medicaid benefits. Use Code P with Codes 5, 7 and 8.

Q – Proof of THSteps Screening — Identifies a child who the automated system indicates as delinquent in screening, but for whom the individual has provided proof of THSteps screening. This code does not remain on SAVERR. Use Code Q only with Code 5.

R – HHSC Employee — Identifies a person who is an HHSC employee. Use Code R with all primary codes.

S – Alien with Acceptable Alien Status — Identifies a noncitizen whose alien status allows him to receive TANF. Use Code S with all primary codes. **Note:** Do not use this code for refugees (SIG H).

T – Ineligible Alien — Identifies a person ineligible due to alien status. Use Code T with Codes 9, 0 and 2Y.

U – Ineligible — No U.S. Citizenship Proof— Identifies a person ineligible due to no proof of U.S. citizenship. Use Code U with Codes 0, 2I or 2Y.

V – Living in Nursing Home — Identifies a person who is temporarily in a nursing home. Use Code V with Codes 0, 3, 5, 6, 7 and 8.

W – Disqualified Child – Identifies a child disqualified for failure to comply with employment services or SSN requirements. Also identifies a minor parent certified as a child, who is disqualified for not cooperating with child support requirements. Use Code W only with Code 2.

X – Deceased – Identifies a deceased person. Use Code X with Codes 5, 6, 7 and 8. Enter the date of death in Item 47 when using Code X.

Y – Disqualified Second Parent — Identifies a legal parent who would be required to be included as a second parent but who is disqualified. Use Code Y only with Code 2.

Z – Migrant — Identifies members of a migrant household. Use Code Z with all primary codes.

SNAP

Head of Household Codes

A — The head of household is a household member.

G — The head of household is a nonmember.

GK — The head of household is disqualified for a reason other than an intentional program violation (IPV).

GT — The head of household is disqualified for an IPV.

Other Codes

B – Student — Identifies a member who is eligible to participate even though he is a student enrolled at least half time in a curriculum that requires a high school diploma or equivalent for entrance.

C – ABAWD not meeting the work requirement — Identifies an able-bodied adult without dependents (ABAWD) who is not meeting the 18-50 work requirement.

D – ABAWD meeting the work requirement — Identifies an ABAWD who is working 20 or more hours per week or is in a work program that meets the 18-50 work requirement.

F – Treatment Facility Residents — Identifies a

- participating resident of an approved drug and alcohol treatment/group living arrangement facility; or
- resident of a public institution who jointly applies for SSI and SNAP.

H – Eligible Refugee — Identifies a person identified as an eligible Amerasian, refugee, asylee, victim of severe trafficking, or Cuban/Haitian entrant by the U.S. Citizenship and Immigration Services (USCIS) on Form I-94 or other USCIS document. Continue using Code H until the individual has resided in the U.S. for five years. **Note:** If the Category is 8 and Aid Type is 5, all household members must be coded H.

K – Disqualified for a reason other than an IPV— Identifies a member who is disqualified for any reason other than an IPV. Even though this person is not eligible to receive SNAP, enter his biographical data.

M – Migrant, Out of Work Stream — Farm workers who travel to work in agriculture or a related industry during part of the year but who are presently residing at their permanent or home base.

R – HHSC Employee — Identifies a person who is currently an HHSC employee.

S – Eligible Alien — Identifies a noncitizen whose alien status allows him to receive SNAP. Use Code S with all primary codes. **Note:** Do not use this code for refugees.

T – Disqualified for Intentional Program Violation— Identifies a person who is disqualified for intentional program violation. This person is not eligible to receive SNAP; however, all biographical data, income, and expenses are entered. When using Code T, make an entry in Item 49, Disqualification Code and Date.

U – Seasonal Farm Worker — Farm workers who do not leave their permanent residence to work in agriculture or a related industry.

W – Migrant, in Work Stream — Farm workers who are presently employed away from their permanent residence or home base.

Medical Programs

Primary Codes

2 – Disqualified/Ineligible Child or Second Parent— Identifies a child or adult who is not eligible for Medicaid, but who is included in the budget group. Do not use SIG Code 2 for an ineligible person who is the case name. On GWS, the SIG labeled "Other Rel Spouse" also results in this SIG. The "Other Rel Spouse" label is used to identify the spouse of the "Caretaker/Other Rel." This individual is not eligible for Medicaid but is included in the budget group.

4 – Eligible child – Identifies a child who meets the Medicaid eligibility requirements for the current period and/or prior period or who would meet those requirements if still alive.

7 – Second Parent — Identifies either the

- eligible spouse of a dependent child's natural or adoptive parent, or stepparent; or
- second adult in an RMA case.

Do not use Code 7 for an SSI recipient, to identify the case name, for more than one member, or unless a caretaker is certified.

8 – Caretaker — Identifies the

- eligible pregnant woman;
- eligible caretaker in the home;
- independent child who applied for himself, and, if applicable, his siblings; or
- first adult or single adult in RMA cases.

Do not use Code 8 for an SSI recipient (see Code 9-Payee) or for more than one member.

On GWS, the SIG labels "Caretaker/Parent" and "Caretaker/Other Relative" result in this SIG if the individual is eligible for Medicaid on the case.

9 – Payee — Identifies the ineligible case name/payee only. Use SIG Code 9 when the person with the case name is not part of the budget group. Use this code when SSI recipients act as case names/payees.

0 – Case Name Only — Identifies the ineligible caretaker who is part of the budget group and is the case name. On GWS, the SIG labels "Caretaker/Parent" and "Caretaker/Other Rel" result in this SIG if the individual is not eligible for Medicaid on the case. Only one person per case may be coded 0.

Use SIG 0Y for legal parents who are disqualified for TPR, SSN or Child Support noncooperation. On GWS, the SIG label will remain "Caretaker/Parent."

Secondary Codes

E – Federally Recognized Tribe or Unaccompanied Refugee Minor(URM) — Identifies individuals who are either members of a federally recognized Indian tribe or a URM. These individuals are exempt from mandatory enrollment in Medicaid managed care.

H – Eligible Refugee — Identifies a person who is a refugee. Use Code H with all primary codes in Categories 1 through 5.

I – Ineligible Child – Identifies a child disqualified for Medical Program. Use Code I only with Code 2.

K – Child of a Minor Child – Identifies the child of a young mother who is also included in the budget group. Use Code K only with Code 4.

L – Minor Child with a Child of Her Own — Identifies a mother 18 years old or younger who has a child of her own in the same budget group. Use Code L with Codes 4, 7, 8 or 0.

M – Eligible Only for Three Months Prior Medical Assistance— Identifies a person who is eligible for medical assistance during any or all of the three months before the month of application, but who is not currently eligible for medical assistance. Use Code M with Codes 4, 7 or 8.

N – Ineligible for Retroactive Medical Assistance and Current Assistance — Identifies an ineligible member of the budget group who must be reported to certify a case for three months prior Medicaid coverage. Use this code for a member of the budget group who is ineligible for retroactive medical assistance and current assistance. Use Code N only with Code 2.

O – DSHS Child with Special Health Care Needs— Identifies a child who is exempt from mandatory enrollment in Medicaid managed care.

P – Private Health Insurance — Identifies a certified person who has private health insurance for hospitalization, accidental injury or sickness, other than Medicare or Medicaid benefits. Use Code P with Codes 2, 4, 7, 8 or 0.

Q – THSteps, Family Planning, or Other Service Needs— Identifies a Medicaid recipient, from birth through 18, who does not want THSteps or family planning services or who does not require assistance with other health or income-related needs. Use Code Q only on applications with Codes 4, 7 or 8.

R – HHSC Employee — Identifies a person who is an HHSC employee. Use Code R with all primary codes.

S – Alien with Acceptable Alien Status — Identifies a noncitizen whose alien status allows him to receive Medicaid. Use Code S with all primary codes. **Note:** Do not use this code for refugees (SIG H).

T – Ineligible Alien — Identifies a noncitizen whose alien status makes him ineligible for program benefits. Use Code T with Codes 2, 9 or 0.

U – No U.S. Citizenship Proof — Identifies a person ineligible due to no proof of U.S. Citizenship. Use Code U with Codes O, 2I or 2Y.

V – Living in Nursing Home — Identifies a person who is temporarily in a nursing home. Use Code V with Codes 4, 7 or 8.

W – Disqualified Child – Identifies a child disqualified for failure to comply with or SSN requirements, or a minor parent who is disqualified for not cooperating with child support requirements. Use Code W only with Code 2.

X – Deceased – Identifies a deceased person. If using Code X, enter the date of death in Item 47, Death/Denial Date. Use Code X with Codes 4, 7 or 8.

Y – Disqualified Caretaker or Second Parent— Identifies a legal parent who would be required to be included as a caretaker or second parent but who is disqualified for citizenship, TPR, SSN or Child Support noncooperation. Use Code Y only with Codes 2 and 0.

Z – Migrant — Identifies members of a migrant household. Use Code Z with all primary codes.

ITEM 41: (W)

TANF and SNAP

Enter an employment services code for each person listed in Item 33. The form will not process if this item is left blank.

If Form H1000-A, Form H1000-B or Form H1000-C is processed for ongoing benefits at application or complete review/recertification, SAVERR only allows a code in Item 41 that corresponds to the appropriate age, based on Item 34, Birthdate. Forms H1000-A (Form H1000-B for SNAP recertifications processed after cutoff of the last benefit month) are edited based on the date the form processes. Other Forms H1000-B are edited based on the form effective date.

For TANF, SAVERR has age edits for codes A and F.

For SNAP, SAVERR has age edits for codes 2, 3, 4, A, F, R, V and W. If Item 78, Type Review, is coded N or I, SAVERR only edits new entries in Item 41 for correctness.

TANF

Codes	Explanation
A	Child (SIG 5 or 5L).
B	A caretaker or second parent, age 18 or younger attending school.
C	Caring for an ill or disabled child in the household, even if the child is not a member of the certified group.
E	Unable to work due to a disability expected to last more than 180 days.
F	60 years of age or older.
G	Caring for a child (SIG 2, 3 or 5) under age 1. Do not use this code if another member is Code G or R.
H	Presence required in the home because of illness or incapacity of another adult member of the household and the disability is expected to last more than 180 days.
J	Not subject to participation – not a certified TANF individual. Use this code with SIG 3and 9, or with SIGs 0 or 2 who are disqualified for a reason other than ESP noncompliance.
K	Pending during appeal of denial or disqualification. Use only for currently certified TANF individuals.
L	County Hardship Exemption – Identifies an individual who has used the maximum number of TANF months allowed in the state time limit but who is certified for TANF because HHSC state office has designated the county as economically deprived.
M	Mandatory registrant.
N	Employment Hardship Exemptions – Identifies an individual who has used the maximum number of TANF months allowed in a state time limit but who is certified for TANF due to lack of employment.
P	Mandatory registrant employed or self-employed 30 or more hours per week and earning at least$700 a month. Do not use this code if the individual qualifies for exemption codes A, B, F, G, R, C, J, N, Q, W or L.
Q	Severe Personal Hardship Exemption – Identifies an individual who has used the maximum number of TANF months allowed in a state time limit but who is certified for TANF due to a disabling illness or injury of self or a close family member in the home.
R	Caring for a child under age 1 who is not listed on Form H1000-A, Form H1000-B and Form H1000-C. Do not use this code if another member is coded G or R.
T	Pregnant and unable to work.
U	A single grandparent age 50 or over caring for a child under age three.
V	An SSI recipient parent.
W	Identifies an client who noncomplies with the Choices program. There must be financial penalty of F, S or T entered on Form H1000-C.
X	A parent who has exhausted state time limits.
Y	A parent who is disqualified due to third party resource (TPR) requirements, Social Security number requirements, intentional program violation, failure to report a child's absence, being a fugitive, having a felony drug conviction, failure to cooperate with Quality Control or noncompliance with the unmarried minor parent domicile requirement.

SNAP

Codes	Explanation
A	Child age 16 years of age, or child age 16 or 17 who attends school at least half-time, or is not the head of household.

Codes	Explanation
D	Three to nine-months pregnant.
E	Physically or mentally unfit for employment.
F	60 years of age or older.
G	Caring for a child under age 6.
H	Presence in home required for care of an incapacitated person.
J	Person in drug addiction or alcoholic treatment and rehabilitation program.
N	Receiving or applying for unemployment compensation.
P	Employed or self-employed 30 hours or more a week.
Q	Individual resides in a Choices county and is mandatory or has volunteered for TANF employment services.
R	Registered again, after previously serving the E&T noncompliance penalty period.
S	Student exemption (age 18 or older)/person in a training program.
T	Disqualified household member (or nonmember head of household).
U	Primary wage earner failed to comply with SNAP employment services.
2	Registered, employed less than 30 hours a week.
3	Registered, not working.
4	Registered, job attached (temporarily laid off).
5	Registration postponed, expedited service.

TP 40, TP 43, TP 44, TP 48 and TP 55

Enter a citizenship verification code for each person in the certified group who is a U.S. citizen. The codes specify what level of citizenship verification was used to verify citizenship, if an affidavit was used, or if good cause was allowed. When using an affidavit, a fourth level verification, enter 5 instead of 4. The levels of verification sources are found in A-358.1, Citizenship.

Codes	Explanation
1	Primary level verification source used to verify citizenship
2	Level 2 verification source used to verify citizenship
3	Level 3 verification source used to verify citizenship
4	Level 4 verification source used to verify citizenship
5	Affidavit used to verify citizenship
6	Good cause allowed for citizenship verification

ITEMS 42 - 45:

All Programs

Enter income information in Items 42-45, 55 and 56 as appropriate for each individual listed in Item 33. Leave an item blank if the household does not have that type income.

TANF

Do not enter income for persons whose status-in-group is

3 – an SSI child,
9 – a payee, or
2I – an ineligible child.

Note: Enter the deductible amount of any diverted income in Item 58, Deductions, for any individual whose gross income is entered on Form H1000-A, Form H1000-B and Form H1000-C. No individual's deductions should exceed his income.

SNAP

For people disqualified for citizenship, 18-50 work requirement or SSN, enter the prorated amount of income attributed to the household.

Medical Programs

Enter income information for SIG Codes 2, 4, 7, 8 and 0. For TP 45 cases, make no entry in Items 42-44, 55 and 56.

ITEM 42A: Type Income

All Programs

Enter one of the following codes to indicate the type of income entered in Item 44.

A Veterans Affairs (VA) benefits
C Unemployment Insurance benefits
P Pension benefits (other than RSDI, SSI, VA or RR)
M Combination of unemployment benefits with benefits from a pension, VA, or both
W Combined income from VA and a pension

ITEM 42B: Gross Earned

All Programs

Enter the monthly amount of countable gross earned income and net self-employment income, up to seven numeric characters. Also make an entry in Item 118, and in Items 119-122, if appropriate.

ITEM 43: RSDI

All Programs

Enter the monthly amount of Social Security (RSDI) benefits for each person whose income is considered. **Note:** If you enter an amount in this item, you must also make an entry in Item 38.

ITEM 44: VA

All Programs

Enter the monthly amount of VA benefits, unemployment insurance benefits, pension, or any combination of these.

When entering an amount in Item 44, also make entries in Item 42A and Item 118.

ITEM 45: SSI

All Programs

SAVERR will print the active penalty codes for each individual on the Form H1000-A, Form H1000-B and Form H1000-C turnaround.

SNAP

Enter the monthly SSI benefit amount.

ITEM 46: Medical Effective Date

TANF and Medical Programs

Enter the beginning date of Medicaid coverage for each person certified for cash and/or medical coverage. Leave blank for status-in-group Codes 0, 2, or 9 and 3 for TANF.

There are many edits associated with the medical effective date. If the correct medical effective date cannot be entered, submit Form H1107, Request for Forced Change of Medical Coverage, to State Office Data Integrity (SODI) Section, SDX Eligibility Unit, State Office, Y-922.

If a recipient has previous medical coverage with HHSC, enter the nine-digit client number or Code 2 in Item 32, Client Number.

TP 55 and 30

For applications with spend down, enter the earliest possible Medicaid eligibility date (MED) for each SIG 4, 7 and 8.

TP 30

Enter the date the emergency conditions started. Use the date the practitioner entered on Form H3038, Emergency Medical Services Certification.

ITEM 47: Death/Denial Date

TANF and Medical Programs

If appropriate, enter the date of denial (always the last day of the month) or date of death(always the actual date of death) for each person.

The following situations require an entry for certified group members.

- A case is released from hold to deny benefits. If the members of the certified group are not eligible for Medicaid benefits for the hold effective month, enter the last day of the month before the hold effective month.
- A case is released from hold and an eligible individual's SIG is changed to an ineligible SIG.

If the case is active and the individual's status-in-group code is changed from eligible to ineligible, do not enter a date in Item 47.

If an active case is denied, this item shows the effective date of denial of Medicaid coverage for all individuals who have medical coverage.

TP 55 and 30

Edits for cases with spend down will not allow a date in this item that is later than the application month.

TP 30

Make an entry only for the certified member (open/close code 090).

ITEM 48: FS-Med Cost; PA-Refugee

TANF and Medical Programs

Enter the code that indicates Voluntary Resettlement Agency (VOLAG), nationality, and U.S. entry date for each refugee. The first digit is the VOLAG code, the second and third digits are the nationality code, and the fourth through seventh digits are the two-digit month and the last two digits of the year of U.S. entry.

Codes	Voluntary Resettlement Agency (VOLAG)
0	Tolstoy Foundation or American Fund for Czechoslovak Refugees
1	YMCA
2	United States Catholic Conference (USCC)
3	Church World Services (CWS)
4	Lutheran Immigration Aid Society (LIRS)
5	Hebrew Immigrant Aid Society (HIAS)
6	International Rescue Committee (IRC)
7	World Relief Services
8	American Council for Nationalities Services (ACNS)
9	Persons Granted Asylum

Codes	Nationality	Codes	Nationality
01	Cuban	17	Chinese
02	Cuban/Haitian Entrant	18	Chilean
03	Soviet Jew	19	El Salvadoran
04	Romanian	20	Brazilian
05	Hungarian	21	Colombian
06	Iranian	22	Palestinian
07	Iraqi/Kurd	23	East German
08	Afghan	24	Pakistani
09	Argentinean	25	Bulgarian
10	Nicaraguan	26	Yugoslavian
11	Ethiopian	27	Armenian
12	Somali	28	Turkish
13	Other African	29	Portuguese
14	Polish	30	Peruvian
15	Czechoslovakian	99	State office use only (do not enter)
16	Indochinese — Vietnamese, Cambodian, Laotian, Khmer, Hmong -		

Example: An Indochinese resettled by World Relief Services who entered the U.S. in June 1979 is entered 7160679.

Note: Information recorded in Item 48 cannot be changed via Form H1000-A, Form H1000-B and Form H1000-C. To change this item, send a memorandum requesting the change to State Office Data Integrity, Special Programs Support Unit, Y-922.

SNAP

Enter the total monthly amount of medical costs of each person who is eligible for the deduction. Allowable expenses of a person who is no longer a household member are entered on line "a" of this item and credited to the head of household. Do not reduce this amount by $35. If none, leave blank.

ITEM 49: Disq. Code and Date

SNAP

Only the State Office Claims Investigation Unit (SOCIU) can enter, change or authorize deletion of entries in this item. Use this item in active or denied SNAP cases if a member has been disqualified for an intentional program violation (also see Item 40). The entry must always be six full characters. Contact the SOCIU if changes must be made in this field.

The first character SOCIU enters is:

T administrative disqualifications for offenses that occurred prior to Sept. 22, 1996;
S administrative disqualifications for offenses that occurred on or after Sept. 22, 1996, or disqualifications for convictions due to trafficking;
C court-ordered disqualifications; or
M disqualifications due to receipt of multiple benefits in one month.

The second digit SOCIU enters is:

- 1, 2 or 3 depending on whether this is the person's first, second, or third disqualification for intentional program violation (see B-912, IPV Disqualification Penalties, for lengths of penalties associated with each violation); or
- 4 if the disqualification is a permanent disqualification for trafficking in SNAP benefits or program access devices of $500 or more.

The remaining characters SOCIU enters are:

- the last month of the disqualification period entered in the MMYY format, or
- PERM if the disqualification is permanent.

SOCIU enters the same information whether the case is active or denied, and the penalty period is the same regardless of case status.

Example: For an offense that occurred after Sept. 22, 1996, a person is disqualified for an intentional program violation through May 1999. This is the person's second disqualification. SOCIU enters "S20599" to show that the disqualification is his second and that he is disqualified through May 1999. If the disqualification is his third, SOCIU enters "S3PERM" to show the disqualification is permanent.

ITEM 50: Client Number Validation

All Programs

Enter the client number if validation of the number entered in Item 32 is required. See instructions for Item 32. Use the validation only if reassigning a client number or changing individual biographical information.

Warning Messages

All Programs

SAVERR prints warning codes if the last input document is incomplete, questionable or invalid. If the head of household has had a name change because of hierarchy, the old name is printed after any warning messages in Item 50. The following format is used for all error messages: AAABBCCC

AAA — Form item number 001-191; client items 32-50 will be shown A32-K32, through K50. When a client item is shown without line indicator, 032-050, then the comparison of all entries within that item caused the error.

BB — One of the following two-digit qualifiers:

EC – ERROR CODE NUMBER "CCC"
EQ – EQUAL
GE – GREATHER THAN OR EQUAL
GT – GREATHER THAN
LE – LESS THAN OR EQUAL
LT – LESS THAN

NA – NOT ALLOWABLE WITH THE ENTRY OR LACK OF ENTRY IN"CCC"
NE – NOT EQUAL

CCC — Form item number 001-191; or error code number 300-999; or one of the following "KEY" words:

ALP – ALPHABETIC
BLK – BLANK
CUR – CURRENT PROCESS MONTH
DAT – VALID DATE
FIL – VALUE ALREADY ON FILE
N-3 – today minus 3 months
N-6 – today minus 6 months
N12 – today minus 12 months
N24 – today minus 24 months
N45 – today minus 45 days
NAM – NAME FORMAT
NOW – PROCESS DATE OF FORM
NUM – NUMERIC
NXT – NEXT PROCESS MONTH
VAL – VALID

TANF

If at application or complete review the advisor assigns a ...	SAVERR prints the message ...
three-month periodic review,	"ERRPRONE."
12-month periodic review,	"EXTENDRV."

C—520.4 Section IV, Items 51 - 59

Revision 08-4; Effective October 1, 2004

ITEM 51: Total Earned

All Programs

This computer-printed item is the sum of the entries in Column 42B, Gross Earned.

ITEM 52: Total RSDI

All Programs

This computer-printed item is the sum of the entries in Column 43, Retirement, Survivors, and Disability Insurance (RSDI).

ITEM 53: Total VA

All Programs

This computer-printed item is the sum of the entries in Column 44, VA.

ITEM 54: Total SSI

SNAP

This computer-printed item is the sum of the entries in Column 45, SSI.

ITEM 55: Total RR

All Programs

Enter the total monthly railroad retirement benefits for people whose income is considered. Include any railroad retirement benefits received by a person disqualified because of SSN or citizenship policy and attributed to the household. If none, leave blank.

ITEM 56: Other Income

All Programs

Enter the total monthly unearned income from all sources not included in other data boxes. If none, leave blank.

TANF

This may include applied income, countable child support, or alien sponsor's income.

SNAP

This includes the portion of other income of a disqualified person, or a sponsor's income, attributed to the household.

Medical Programs

This may include the TANF grant, total gross child support, and countable income from an alien's sponsor.

ITEM 57: Total Income

All Programs

This computer-printed item is the sum of the entries in Items 51 through 56.

ITEM 58: Deductions

TANF

Enter the standard work related expense deductions for SIG 2W, 2Y, 5, 7, 8 and 0 members with earned income counted against recognized needs. The deductions cannot exceed the members' monthly earnings. Also enter any amounts diverted from the income of a:

- caretaker,
- disqualified legal parent (SIG 0), or
- disqualified second parent (SIG 2Y).

If there are no deductions, leave blank.

Note: Do not enter child care expenses or the 90% earned income deduction in this item. See instructions for Items 149-152.

SNAP

Enter the household's total monthly dependent care costs, the amount of legally obligated child support paid to or for a nonhousehold member and the remaining farm loss.

Medical Programs

Enter income deductions for everyone whose income is considered in the case, including ineligible people. Enter work-related expenses, child support disregard and any diversions for everyone. If there are no deductions, leave blank. **Note:** Do not include child care expenses (see instructions for Items 149-152).

ITEM 59: Adjusted Gross Income

All Programs

Enter the adjusted gross income. Enter 0 if there is no adjusted gross income.

TANF

The total case income, minus Item 58 equals Item 59, unless child care costs are entered in Item 152 or the automated 90% earned income deductions is used. For these exceptions, the total income minus Items 58, and 152 (child care and 90% earned income deduction amounts) equals Item 59.

Medical Programs

The total case income minus Items 58 and 152 (child care) must equal Item 59.

C—520.5 Section V, Items 60 - 77B

Revision 05-4; Effective August 1, 2005

ITEM 60: Shelter

SNAP

Enter the total amount of the household's monthly shelter costs. Enter zero, if there are no shelter expenses. Coordinate this item with Item 90, Utility Standard Code.

ITEM 61: Adj Gross Income

SNAP

Computer printed on Form H1000-B and Form H1000-C. Make no entry.

ITEM 62: Excess Shelter

SNAP

Computer printed on Form H1000-B and Form H1000-C. Make no entry.

ITEM 63: Net Income

SNAP

Enter the household's rounded net income. Enter zero, if there is no net income.

ITEM 64: Blank

ITEM 65: Benefits

SNAP

Computer printed on Form H1000-B and Form H1000-C. Make no entry.

ITEM 66: Total Needs

TANF

Enter the total budgetary needs figure for all members of the TANF group. Enter a new figure each time the certified group size changes.

Medical Programs

Type Program	Enter on Form H1000-A
40	185% Federal Poverty Income Limit (FPIL).
43	185% FPIL.
44	100% FPIL.
45	Leave Blank.
47	TANF budgetary needs (100%) allowance figure for all members of the budget group.
48	133% FPIL.
55	Medically Needy Income Limits for all members of the budget group.

For TP 30 cases, if Item 137 has an entry of:	Enter
40	185% FPIL
43	185% FPIL
44	100% FPIL
48	133% FPIL
55	Medically Needy Income Limits

Enter a new figure on Form H1000-B and Form H1000-C each time the household size changes. Item 66 must agree with Items 40, 125, and 126.

ITEM 67/67A: Recog/Max (Recognizable Needs/Maximum Grant)

TANF and Medical Programs

These figures are computer printed. There is no 67A entry for Medical Programs.

ITEM 68/68A: AGI (Adjusted Gross Income)

TANF and Medical Programs

These figures are computer printed. Item 68 equals the entry in Item 59. For TANF, Item 68A is the rounded down figure of Item 68. There is no Item 68A entry for Medical Programs.

ITEM 69: Unmet

TANF and Medical Programs

This figure is computer printed and is the balance of Item 68 subtracted from Item 67.

TANF

This item shows an unmet need of

- at least one cent for active TP 01, 11, and 61 cases; and
- zero cents for TP 07 and 37 cases.

Medical Programs

For ...	this item ...
TP 40, 43, 44, 47, and 48 cases,	shows an unmet need of at least one cent.
TP 55 and 30 cases that are not subject to spend down,	shows an amount greater than or equal to zero will be shown.
TP 55 and 30 cases that are subject to spend down,	shows a negative amount, which represents the monthly spend down.
TP 45	will be blank

ITEM 70: Recommended Grant Amount

TANF

This figure is computer printed and is the balance of Item 68A subtracted from Item 67A. The minimum grant of $10 is printed in Item 70 if the balance is less than $10. This item indicates benefit amount, less recoupment, if applicable. This amount is printed only for TP 01 and 61 cases.

Medical Programs

This item is computer printed. SAVERR prints a spend down amount in Item 70 if the amount in Item 69 is a negative amount. Otherwise, Item 70 will be blank.

ITEM 71 - 77-B: MAO Only

Make no entry.

C—520.6 Section VI, Items 78 - 110

Revision 10-2; Effective April 1, 2010

SNAP

Items 78, 83, 84, and 90 cannot be deleted, but may be updated. Items 86, 87, 88, 89, and 93 may be deleted with a pound sign.

ITEM 78: TR (Type Review)

SNAP

Make no entry on Form H1000-A, Notice of Case Action. SAVERR returns Form H1000-B, Record of Case Action, and Form H1000-C, Secondary Client Input, sequence 02 with Code C. Enter one of the following codes on later Form H1000-B and Form H1000-C:

C — Complete review

I — Incomplete review

N — Non-review activity (case maintenance)

State Office Review Codes

M — SNAP "end-of-month" conversion

O — SNAP conversion that occurs at September cutoff effective October (**Example:** SNAP allotment conversion)

1 — SNAP annual RSDI/SSI conversion

ITEM 79: App. Codes (Application Codes)

SNAP

Enter the three-digit code from the list below that describes the type of application, the referral, and the number of months since the previous application or certification period.

The first digit is the type application:

1 — Eligibility Determination – individuals who are not currently certified or individuals submitting untimely reapplications.

2 — Redetermination (Reapplication) – individuals submitting timely applications for continued benefits.

3 — Application reopened after denial using the same Form H1010-B.

The second digit is always "X."

The third digit is

0 — All initial applications, reapplications within 30 days from previous application, or later applications within 30 days after the end of the previous certification period.

1-8 — For one month, enter 1, for two months, enter 2, etc.

9 — Nine months or longer.

ITEM 80: Certification Date

SNAP

Enter the month, day, and year the certification period begins. The day is always 01, even if the whole allotment is prorated.

ITEM 81: MOS. CERT. (Months Certified)

SNAP

Enter the number of months of the certification period. This must be a two-digit number.

ITEM 82: Last ATP Date (Last Benefit Month)

SNAP

Enter the month and year that the individual receives his last benefits for the current certification period. This must correspond to Items 80 and 81.

ITEM 83: HH NO. (Household Number)

SNAP

Enter the number of certified persons in the household. This is the same as the number of eligible persons listed in Section II. Do not include status-in-group Codes G, K, or T. This must be a two-digit number.

ITEM 84: AID (Aid Type)

SNAP

Enter the code that refers to the type of SNAP case.

1 — NPA only. No members receive TANF. (Category 9)

2 — NPA mixed. Some members receive TANF or RCA and others do not. (Category 9)

3 — PA. All members receive TANF or some receive SSI and other others receive TANF. (Category 6)

5 — All members are refugees, other than Cubans or Haitians, receiving TANF or RCA. (Category 8)

ITEM 85: Test

SNAP

Enter a code to indicate the household's categorical eligibility/income test/shelter deduction..

B — Gross and net income tests and capped shelter deduction.

C — Categorically eligible household with capped shelter deduction.

E — Gross and net income test and uncapped shelter deduction. Use this code only if the member who is entitled to uncapped shelter costs is disqualified for intentional program violation.

M — Net test only, uncapped shelter deduction.

T — Categorically eligible household with uncapped shelter deduction.

SNAP-CAP

S — Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP), entered by Centralized Benefits Services.

ITEM 86: PR (Intentional Program Violation Referral)

SNAP

Make no entry. A "Y" is printed during OIG's investigation to prevent the case from being purged.

ITEM 87: NON (Non H/H Members)

SNAP

Enter the code that identifies the non-participating or non-household member(s).

A — Attendant

B — Boarders

C — Ineligible alien

D — Ineligible student

E — Any combination of two or more of A, B, C, or D

If an attendant, boarder, or roomer is an ineligible alien, code him here and in Item 88.

ITEM 88: INELIG. (Ineligible)

SNAP

Enter the total number of persons living in the SNAP household who are not eligible for participation because they are ineligible aliens.

ITEM 89: SSI

SNAP

Advisors enter an "X" if every household member receives SSI. If one or more household members do not receive SSI, leave blank.

SAVERR enters an "A" when a case transfers to Centralized Benefits Services (CBS). CBS enters an "R" when transferring a case to the field.

ITEM 90: UTIL (Utility Expense Code)

SNAP

Enter the appropriate code to describe utility and telephone costs.

Code	Description
1	Household claiming the Standard Utility Allowance.
2	Household claiming the telephone standard only.
4	Household without utility costs.
8	Households claiming the homeless shelter standard.
9	Households claiming the homeless shelter standard with one member who is disqualified for not meeting citizenship, 18-50 work and/or SSN requirements.
A	Households claiming the Basic Utility Allowance.

Do not prorate the utility and telephone standards for households with disqualified members or households sharing expenses.

ITEM 91: Action Code

SNAP

Enter the appropriate denial code. Leave blank unless the case is denied or is opened and closed on the same document. If an entry is made in Item 91, the advisor must also make an entry in Item 92. See C-221, Denial Codes, for denial codes.

ITEM 92: Action Date

SNAP

Enter the effective date of denial. If denying an application, enter the date you determine the case is ineligible. If the application is opened and closed or an active case is denied, enter the last day of the last month in which the household receives its final benefits. When making an entry in Item 92, also make an entry in Item 91.

ITEM 93: Texas Driver's License Number

SNAP

Enter the head of household's Texas driver's license number or Texas Department of Public Safety(DPS) ID number. If the head of household does not have a Texas driver's license or DPS ID, leave blank. Enter a leading zero for seven-digit license numbers.

ITEM 94: Reserved

ITEM 95: Code/Hold Date

SNAP

Enter the appropriate hold or release code under CD. Make no entry under DATE. SAVERR enters the month after cutoff as the hold effective month.

Hold Benefits

Advisor Hold Code

2 — Use to prevent SAVERR from issuing the next month's benefits. The hold is effective the first of the next SAVERR process month. Use code 2 when

- a change must be made effective the next month and the notice of adverse action expires between cutoff and the end of the month;
- an individual cannot be located;
- the second or subsequent month's benefits must be held because of expedited certification pending verification; or
- a household member receives benefits pending receipt of a social security number.

Note: Entry of Code 2 does not prevent entry of information in other sections, including Section XI, to cancel benefits or issue benefits for the current processing month.

State Office Hold Codes:

A — Form H1000-B, submitted to deny a case, contains a fatal error that is not cleared by cutoff. The case remains on hold until the erroneous Form H1000-B is corrected and processed.

Z — The EBT account is dormant because the household has not accessed benefits for three consecutive months or six consecutive months when the most recent monthly issuance is less than $20.

Release Codes

O — Releases benefits effective the first of the next SAVERR process month. Release any held benefits, as necessary, by completing Section XI. **Note:** In case actions involving a hold Code A, enter a release code only if the case will not be denied.

ITEM 96: (Late Determination/Rescheduled Appointment Date)

SNAP

Make an entry if

- someone files an application, untimely reapplication or a timely application for a recertification, misses the first appointment, and schedules a subsequent appointment. Enter the date (mmddyy) of the latest appointment.
- expedited benefits are delayed because of a late determination caused by the applicant. Enter the date (mmddyy) that all the following have been completed:
  - Form H1010-B, Application for Assistance - Part B: Information We Need to Know, completed and signed,
  - individual or authorized representative interviewed, and
  - identification verified.

SSI/SNAP Prerelease Joint Application

If SSA does not notify HHSC of an individual's release until after the actual release date, enter the date (mmddyy) of notification.

ITEM 97: PASS Account Amount

SNAP

Enter PASS account amount.

ITEM 98A/B: Verification Requested/Received

SNAP

Make an entry in this item when:

- processing a timely recertification,
- the individual missed the first appointment,
- verification can be requested up to the 15th day of the month following the last benefit month, and
- Form H1020, Request for Information or Action, due date is after the last benefit month.

Use 98A to enter the date (mmddyyyy) the verification is requested.

Use 98B to enter the date (mmddyyyy) the verification is received. If no verification is received, do not enter a date.

The paper Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action, or Form H1000-C, Secondary Client Input, does not correctly reflect the two separate items; however, advisors are able to enter both dates in Item 98.

Example: Item 98 09252000 10052000

ITEM 99: Ineligible Month/Combined Allotments

SNAP

Enter the appropriate code if the household is ineligible for the month of application or the second month.

1 — No benefit issued for month of application due to proration, but eligible for the second month as a combined allotment.

2 — Eligible for month of application but ineligible for the second month.

ITEM 100: PASS Account Code

SNAP

Enter the appropriate PASS account code.

E — Exempt from earned income

U — Exempt from unearned income

ITEM 101: (Prepared Meals Services Code)

SNAP

Enter the appropriate code to identify a household that qualifies to use SNAP benefits to purchase prepared meals from one of the following authorized meal providers:

C — SSI/elderly member authorized to purchase from communal dining facilities, meal delivery service, or contracted restaurant.

E — Homeless and either elderly or SSI recipient; authorized to purchase from every service(communal dining, meal delivery services, or homeless meal providers/contracted restaurants).

H — Authorized to purchase from homeless meal providers/contracted restaurants.

M — Household/disabled member authorized to purchase from meal delivery services.

ITEM 102: Reserved

ITEM 103: (Special Review Date)

SNAP

Enter the month and year for the special review (**Example:** 08-96).

ITEM 104: (Special Review Code)

SNAP

Enter the appropriate code to show the type of special review needed.

0 — State office assigned

1 — Employment Services/Work Registration

2 — School Attendance

3 — Reserved

4 — Management

5 — Income/Expense changes anticipated

6 — Living arrangement change anticipated

7 — Medical review

8 — Household change anticipated

9 — Other

To delete Items 103 and 104, enter pound (#) in 104.

ITEM 105 - 110: Reserved

C—520.7 Section VII, Items 111 - 126

Revision 02-6; Effective July 1, 2002

ITEM 111: Reserved

ITEM 112: First Case Number

All Programs

Enter the associated TANF, SNAP or Medical Programs case number.

ITEM 113: Second Case Number

All Programs

If Item 112 has an entry and there is another associated case, enter the second case number in Item 113.

ITEMS 114 - 117: Reserved

ITEMS 118 - 122

All Programs

State office uses Items 118-122 to determine discrepancies between income reported to the advisor and income reported by other agencies for the same person. Complete Items 119-122 when the earned income for a former month is not the same as the earned income entered in Item 42B for the ongoing budget. **Note:** Do not report unearned income that differs from entries in Item 44. If entries are made in Items 119-122 for TP 30 or 55 cases, make appropriate entries in Section XI for the Spend Down history file.

ITEM 118: Mo. Earned (Month Income Is Received)

All Programs

Make an entry in Item 118 only when making or changing an entry in Item 42-B or 44.

Enter a two-digit number to identify the earliest month of certification in which the amounts entered in Items 42B and 44 were received **Example:** If certification date is May 1, the ongoing budget is effective June 1, and income for May is the same as June, then enter "05."

Note: If zero is entered on Form H1000-B, Items 42B or 44, because income currently shown in these items terminates, enter the two-digit number to identify the first month the income was not received.

ITEM 119: First Budget Mo.

All Programs

Make a two-digit entry to identify the first month earned income was different than the current earned income entered in Item 42B. Make this entry even if earned income for this month totals zero.

ITEM 120: Earned Income First Month

All Programs

Enter the total amount of countable gross earnings for the household that corresponds to the month entered in Item 119. Make an entry even if the earned income for this month totals zero.

Exception: Enter the total amount of a disqualified person's earnings, even if budgeting only a prorated amount of his income.

ITEM 121: Earned Income Second Month

All Programs

Enter the total amount of countable gross earnings for all household members corresponding to the month entered in Item 122. Make an entry even if the earned income for this month totals zero.

Exception: Enter the total amount of a disqualified person's earnings, even if budgeting only a prorated amount of his income.

ITEM 122: Second Budget Mo.

All Programs

Enter the two-digit number to identify the second month in which total earned income received is different from the total of the amounts entered in Item 42-B. Make an entry even if the earned income for this month totals zero.

ITEM 123: Face-to-Face for HCO

TP 43, TP 44, TP 47 and TP 48

SAVERR enters code "N" for a caretaker required to have a Health Care Orientation (HCO). A caretaker who does not comply with the HCO requirement must have a face-to-face interview to renew Medicaid eligibility for the child. When a caretaker has a face-to-face interview to clear non-compliance, enter code "F" in Item 123.

ITEM 124: Reserved

ITEM 125: (Adults)

Medical Programs

Enter the number of adults included in the budget group. Include a minor parent who is SIG 0 on a TP 47 case. Make no entry for TP 45.

ITEM 126: (Children)

Medical Programs

Enter the number of children included in the budget group. Make no entry for TP 45. Include the unborn child in this entry for

- TP 40 cases; and
- TP 43, 44, 47, 48, 30, and 55 cases with "01" entries in Item 128 (B.P.).

Entries in Items 125 and 126 must agree with Item 66.

C—520.8 Section VIII, Items 127 - 152

Revision 10-3; Effective July 1, 2010

TANF and Medical Programs

Section VIII shows case information for TANF, foster care, Refugee Cash Assistance (RCA), and medical programs cases.

ITEM 127: T.P. (Type Program)

TANF

Enter the appropriate code to identify the type program for certifications and denials.

01 — Cash and medical assistance.

04 — Medical Assistance Only - Deceased – Medical assistance only because the applicant(s) dies after the date of application but before certification. Do not use this type program if surviving applicants are eligible to receive cash assistance.

07 — Medical Assistance Only - 12 or 18 Months – TANF or refugee cases that are denied cash assistance because of increased earnings, but are eligible for Medicaid coverage for 12 or 18 months after the last month of TANF eligibility.

11 — Medical Assistance Only - Three Months Prior, not currently eligible or a gap in coverage– TANF individuals eligible for three months prior medical assistance, but who are ineligible in the month of application and later months, or have a gap in coverage.

20 — Medical Assistance Only - Child Support – TANF cases that are denied cash assistance because of child support, but are eligible for Medicaid for four additional months.

29 — Medical Assistance Only – 12 or 18 months post Medicaid following the end of TANF state time limit.

37 — Medical Assistance Only - 12 or 18 Months – TANF cases that are denied cash assistance because of the loss of the 90% earned income deduction, but are eligible for Medicaid coverage for 12 or 18 consecutive months after the last month of TANF eligibility.

61 — TANF-SP cash and medical assistance.

71 — OTTANF – One parent household is eligible to receive OTTANF benefits.

72 — OTTANF – Two parent household is eligible to receive OTTANF benefits.

Note: To change the type program and case name, two transactions must be processed.

Category 05 is the RCA program. TP 08, 09, and 10 are foster care programs.

Medical Programs

Enter the appropriate code to identify the type medical program for certifications and denials.

40 — Pregnant woman

43 — Children under age one

44 — Children age six through 18

45 — Newborn children

47 — Dependent children ineligible for TANF because of applied income

48 — Children ages one through five

55 — Medically Needy (with or without spend down)

30 — Nonimmigrants and undocumented aliens

ITEM 128: B.P. (Base Plan)

Medical Programs except TP 40

Enter 01 to identify cases with a pregnant woman in the budget group.

ITEM 129: Grant Eff. Date

TANF

Enter the first day of the earliest month and year the individual is eligible for and is authorized to receive benefits in the same amount as shown in the ongoing budget. Use this item to authorize benefits for the current and previous months.

ITEM 130: RSDI Increase Reserved

ITEM 131: T.R. (Type Review)

TANF and Medical Programs

Enter one of the following codes on Form H1000-A, Form H1000-B and Form H1000-C.

C — Complete

I — Incomplete

N — Nonreview activity (case maintenance)

ITEM 132: Action Code

TANF and Medical Programs

Enter the code that describes the reason for the action taken on the case. See C-200 for Item 132 codes.

ITEM 133: 3 MO. I (Three Months Prior Indicator)

TANF and Medical Programs

Enter the total number of unduplicated calendar months of three months prior Medicaid eligibility. Not applicable for TP 45.

ITEM 134: 3 MOS. PRIOR APP. DATE (Three Months Prior Application Date)

TANF and Medical Programs

When providing prior coverage enter the month and year of the original file date. This date cannot be later than the medical effective date (Item 46) by more than three calendar months. Not applicable for TP 45.

TANF

Use Form H1000-B and Form H1000-C when the requested medical effective date (Item 46) is within six months of the current process month.

ITEM 135: Reserved

ITEM 136: 4 MOS. POST/End Date

TANF

Enter the last month and year for TP 07/20 Medicaid coverage.

TP 40

Enter the second month and year following the expected delivery date.

TP 45

State Office Data Control enters the last month of forced coverage.

TP 43, TP 44, TP 47 and TP 48

Make no entry. This is a computer-calculated end date. If a one or two-month Medicaid extension is needed, update the end date for two months or less in this item, and enter "I" in Item 131.

ITEM 137: SAV (Budget TP)

TP 30

Enter the Budget TP indicator used to determine income eligibility. This is a required entry when processing three months prior or simultaneous open and close situations. Do not make an entry when processing denials.

Enter	For cases that include a
40	pregnant woman who meets the 185% FPIL income criteria.
43	child under age one who meets the 185% FPIL income criteria.
48	child age one through five who meets the 133% FPIL income criteria.
44	child age six through 18 who meets the 100% FPIL income criteria.
55	caretaker/second parent who meets MNIL income criteria.

If the income exceeds the limits and the case is eligible based on TP 55 income criteria with spend down, enter 55.

ITEM 138: (Child Support Cooperation/Reason for Transfer to TP 07/20)

Enter the appropriate code to indicate child support cooperation or noncooperation.

R — Refusal without good cause to cooperate with child support for one or more absent parents.

C — Cooperation. Enter this code if Code R does not apply.

T — No proration when reinstating TANF after PRA cooperation.

Enter Code	If the case transfers to TP 07/20 because ...
E	of new or increased earned income or earnings of a returning absent parent who is added to the certified group.
S	of new or increased child support collections.
B	TANF denial results from a reason listed under Code E, and new or increased child support collections.
P	of PRA noncooperation.

ITEM 139: SPECIAL REVIEW

TANF and Medical Programs (except TP 40, TP 30 and TP 55 with Spend Down)

Enter the date of any contact planned before the date of the next periodic review, or the end of the budget period. For cases with a pregnant woman, enter the first day of the month following the month the pregnancy is anticipated to terminate.

ITEM 140: CODE

TANF and Medical Programs (except TP 40, TP 30 and TP 55 with Spend Down)

Enter the code for the type of special review needed.

1 — Employment Services/Work Registration (TANF only)

2 — School attendance

3 — (Reserved)

4 — Management

5 — Income/Expense changes anticipated

6 — Living arrangement change anticipated

7 — Medical review

8 — Household change anticipated. Note: Use to designate a review for cases with a pregnant woman

9 — Other

Q — Disability Hardship Exemption (TANF only)

To delete a special review date in Item 139, enter a pound sign in Item 140. This entry deletes the information in Items 139 and 140.

ITEM 141: PERIODIC REVIEW

TANF and TP 07, TP 20, TP 37 and TP 55 without Spend Down

Make no entry. This is a computer calculated and printed date of the next periodic review date. If incorrect, enter a new periodic review date in this item and "N" in Item 131.

TP 43, TP 44, TP 47 and TP 48

Make no entry. This is a computer-calculated date that reflects the next required periodic review. If the date is incorrect, enter a periodic review date in this item and "N" in item 131.

ITEM 142: HOLD CD: DATE

TANF and Medical Programs

Enter the appropriate hold or release code under CD. Make no entry under DATE. SAVERR enters the month after cutoff as the hold effective month.

Hold/Release Codes

Advisor

Hold Code 1

Use when the advisor cannot locate the individual and an investigation of the individual's location is pending. This code automatically denies the grant and Medicaid at cutoff of the hold month effective the first day of the hold month. Fiscal cancels any returned warrants and SODI cancels returned Form H3087, Medicaid Identification.

Release: Use Code 8 if the household does not have a new address. Use Code 9 if the household has a new address. Enter the new address on Form H1000-B.

Hold Code 2

Use when appointment of guardian is pending. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-B releasing the hold.

Release: 9 – Enter the name of the guardian on Form H1000-B.

Hold Code 3

Use if changing the payee. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-B releasing the hold.

Release: 0 – Enter the new payee information and complete Section XI on Form H1000-B to issue benefits for hold months.

Hold Code 4

Use when lowering benefits and the adverse action notice period expires between cutoff and the end of the month. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-B releasing the hold.

Release: 0 – Use to release the hold after the adverse action expires. Enter the new budget and/or household composition and complete Section XI on Form H1000-Bto issue benefits for hold months.

Hold Code 5

Use when denying a case or transferring a case to TP 07 or TP 20 and Form H1000-B cannot be submitted because the adverse action period expires between cutoff and the end of the month.

When denying a case, SAVERR does not issue TANF benefits or Form H3087. SAVERR automatically denies the benefit and Medicaid at cutoff of the hold month effective the first day of that month. Fiscal cancels returned warrants and Data Control cancels returned Form H3087.

SAVERR automatically transfers a TP 01 case to TP 07 or TP 20 effective the first day of the next month. SAVERR produces Form H3087 when a case pending transfer is placed on Hold Code 5.

Release: Use Code 8 if the household does not have a new address, responds during the adverse action period, and qualifies for continued benefits. Use Code 9 if the household has a new address, responds during the adverse action period, and qualifies for continued benefits. Enter the new address on Form H1000-B.

State Office Use Only:

Computer-generated Codes

Hold Code A

Form H1000-B submitted to deny a case contains a fatal error not cleared by cutoff. The case remains on hold until the fataled Form H1000-B is corrected and processed. When the form is corrected and the case is denied, enter the correct Death/Denial Date in Item 47.

Release: Use Codes 8, 9 or 0 if the case is not denied.

Data Control Codes

Hold Code C

Form H3087 is returned with postal message: individual moved out of state. State office sends the advisor an RP-24B and sends the individual Form H1029, Notice of Case Action. Automatic denial of the grant occurs at cutoff of the hold month, effective the first day of the hold month.

Automatic denial of Medicaid occurs effective the last day of the month before the hold. Apply this hold only when the message on the returned form H3087 indicates the individual has moved out of state.

Release: Use same release procedures described for Hold Code 1.

Hold Code D

Form H3087 is returned with postal message: deceased. State office sends the advisor RP-24B and holds returned warrants and Form H3087 until the advisor takes action to deny assistance or select a new payee.

Release: Use same release procedures described for advisor Hold Code 3.

Hold Code E

RESERVED

Formerly used when Form H3087 returned with postal message: unclaimed.

TANF

Advisor Codes

Hold Code 2

Use when appointment of a guardian is pending. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-B releasing the hold.

Release: 9 – Enter the name of the guardian on Form H1000-B.

Hold Code 4

Use when lowering benefits and the adverse action notice period expires between cutoff and the end of the month. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-Breleasing the hold.

Release: 0 – Use to release the hold after the adverse action period expires. Enter the new budget and/or household composition and complete Section XI on Form H1000-B to issue benefits for hold months.

State Office Use Only:

Computer-generated Codes

Hold Code 3

At least one refugee in a Category 05 case entered the United States more than eight months ago.

State office sends the advisor a RP-24B and holds warrants and Form H3087 until the advisor takes action to deny the case or delete the person(s) over the eight-month limit.

Release: 0 – Release benefits when deleting all people over the eight-month limit. Deny the case if all members are over the eight-month limit.

Hold Code 6

Case is automatically being denied or transferred to TP 20 because of receipt of child support.

Release: 0 – Use to release and make required entries in Section XI.

Hold Code H

Status-in-group Code 5 individual is age 19 or older. The effect is the same as Hold Code C.

Release: The release procedures are the same as Hold Code 1.

Hold Code L

Individual's state time limit is expiring and SAVERR cannot rebudget the TANF case. Advisor action to rebudget the case is required.

Release: 0 – Release hold and make required budget and Section XI entries.

Hold Code Z

The EBT account is dormant because the household has not accessed it for three consecutive months or six consecutive months when the most recent monthly issuance is less than $20.

Release: The release procedures are the same as Hold Code 1.

Fiscal Codes

Hold Code F

Warrant returned as undeliverable. The effect is the same as Hold Code C.

Release: The release procedures are the same as Hold Code 1.

Hold Code G

Warrant returned with message: deceased. The effect is the same as Hold Code D.

Release: The release procedures as the same as for advisor Hold Code 3.

Hold Code J

Warrant charged back.

Release: Hold is released only by Fiscal Division.

Data Control Codes

Code R

SDX Hold

SDX Release Codes

Code S

Mail benefits using address on SDX.

Code T

Denied

Code X

Deceased

Medical Programs

Advisor Codes

Hold Code 4

Pending assignment of protective payee.

Release: 0 – Release hold and enter protective payee information.

State Office Use Only

Computer-generated Codes

Code 3

Occurs at cutoff in the month:

- a SIG Code 4 child on a TP 44 case becomes age 19, and each following month until the advisor denies TP 44 coverage for the child;
- a SIG Code 4 child on a TP 47 or 55 case becomes age 19; or
- the corresponding case for the mother of the TP 45 child is placed on hold.

Release: Use Code 0.

TP 40

State Office Use Only

Computer-generated Codes

Code H

Occurs at cutoff in the month entered in Item 136. If the advisor does not take action, automatic denial will occur at the cutoff in the following month.

ITEM 143: F. ACT (Future Action)

TANF and Medical Programs

Enter the appropriate action code if placing the case on hold with Code 5.

Item 144 - 148: Reserved

Item 149: Code

TANF and Medical Programs

Use on earned income cases only. Enter C for a child care deduction. This entry requires an entry on the same line in Item 152.

To delete this entry, enter "C" in Item 149 and 0 in Item 152 on the appropriate line.

TANF

Enter 9 for

- a 90% earned income deduction up to $1400 per employed member. This entry requires entries on the same line in Items 151 and 152.
- 12 or 18 months additional Medicaid coverage. This entry requires an entry on the same line in Item 151.

Item 150: From Reserved

Item 151: Through

TANF

Enter the last month of the four-month period of the 90% earned income deduction on the line with Code 9. This also contains the TP 37 end date.

Item 152: Amount

TANF and Medical Programs

Enter the last month of the four-month period of the 90% earned income deduction on the line with Code 9. This also contains the TP 37 end date.

TANF

Enter the allowable amount of actual child care costs on the Code C line.

SNAP

Complete only for cases in which an individual receives or anticipates receiving a TANF child support disregard payment from the Office of the Attorney General (OAG). Enter an amount anytime you

- certify these cases for ongoing benefits, or
- make a change to Form H1000-B that will affect the budget, including disqualifications, changes in household composition, or shelter costs.

Enter six numbers indicating the amount of child support received from the OAG to be budgeted.(**Example:** $25 as 002500.) Enter 000000 if payments were previously reported and have now terminated.

These entries are no longer required if, for the two previous months, the OAG has not reported payments to the individual.

Always enter an amount in Item 56 if you enter an amount in this item.

C—520.9 Section IX, Items 153 - 160

Revision 02-3; Effective April 1, 2002

Item 153 - 160

All Programs

Make no entries in these items.

C—520.10 Section X, Items 161 - 178

Revision 02-3; Effective April 1, 2002

Case Classification (CC)

All Programs

The codes in Section X are not stored in the computer file. They are kept for individual transactions only and are used to complete management reports.

Item 161 - 163: Reserved

Item 164: Case County/Home Phone No.

All Programs

Enter the three-digit code for the individual's residence county, followed by a space. After the space, enter the individual's ten-digit telephone number, including the area code.

Notes:

- See C-350 for the county codes.
- Enter the county associated with the worker's BJN in Item 25.
- Enter only the individual's home telephone number. If the individual has no home telephone number, leave blank.

Item 165 - 167: Reserved

Item 168 - 170: Program Combination Code(s)

All Programs

Use program codes to indicate whether the case action associated with the Form H1000-A, Form H1000-B and Form H1000-C is worked alone or generically with other programs.

Programs	Program Code
TANF only	A
TANF-SP only	U
FS only	F
MP only	M
TANF/FS	AF
TANF-SP/FS	UF
FS/MP	FM
TANF/MP	AM
TANF-SP/MP	UM
TANF/FS/MP	AFM
TANF-SP/FS/MP	UFM

Items 171 - 178: Reserved

C—520.11 Section XI, Items 179 - 187

Revision 04-3; Effective April 1, 2004

TANF

Use this section instead of Form H1008, Authorization for Cancellation or Issuance of Public Assistance Warrants, to request benefits in situations described in the instructions for Item 180. Use Form H1008 to process all other requests for warrant actions. Use this section only for Category 2, TP 01 or 61 cases, or cases being transferred to TP 01 or 61.

Recoupment cannot be done on a benefit requested in Section XI.

SNAP

Use this section to request the issuance and cancellation of benefits.

When reporting a SAVERR or ATA issuance timely on Form H1000-A, Form H1000-B and Form H1000-C, complete Items 118-122 (if appropriate), 179, 180, 183, 184, 185, 186 (if appropriate), and 187.

When reporting an ATA issuance untimely, complete Items 118-122 (if appropriate), 179, 180, 181, 182, 183, 184, 185, 186 (if appropriate), and 187.

TP 55 and 30

Use this section on Form H1000-A with Item 46 to identify any eligible (non-spend down) or potentially eligible (spend down) prior coverage month(s). Use one line for each prior month. Use this section only for consecutive months, with or without spend down. A separate Form H1000-A will be required for any prior coverage months followed by a gap in eligibility. For this section, months with spend down are not considered gaps in eligibility.

Entries in this section for prior coverage cannot precede:

- the third month before the month in Item 08;
- the earliest month of medical coverage entered in Item 46 for any person.

Item 179: ISS/CAN (Issue/Cancel)

TANF

Enter one of the following codes to indicate the type of benefit being requested:

1 — Full month's amounts

2 — Additional benefits for a month; Form H1000-B use only

SNAP

Enter one of the following codes to indicate the method of issuance or to request a cancellation:

S — Untimely reporting EBT issuance via ATA to clear a discrepancy report RF-07E-1. This code can only be used with Code 1 or 3 in Item 180.

E — Requesting EBT issuance or timely reporting EBT benefits issued via the ATA.

N — Requesting cancellation of benefits.

5 — Historical Information: State-office entered. Used to identify a CCDMI as a certified mail issuance. No longer in use effective April 1, 2004.

C — Historical Information: State-office entered. Used to identify a CCDMI that was cancelled. No longer in use effective April 1, 2004.

TP 55 and 30

Enter the appropriate code for each prior month in which a case is eligible or potentially eligible.

N — Not eligible for Medicaid until spend down is met

E — Eligible for Medicaid without spend down

Make no entry for ineligible months. The months reported in this section must be consecutive months of eligibility, with or without spend down.

Item 180: Type ISS.

TANF

Enter the reason for authorization:

9 — Action Code 090, simultaneous open and close on Form H1000-A only. Use to request allowable warrants from Item 129, Grant Effective Date, through Item 47, Denial Date, if the amount equals Item 70, Recommended Grant.

B — Change in both household composition and money reflected in the budget

F — Additional benefits issued due penalty imposed in error

H — Change in household composition

M — Change in money reflected in the budget

Note: Use B, H, and M for certifications and reinstatements, action Codes 57 or lower, to request allowable benefits for the month(s) before the Item 129 entry. These codes identify why the prior amount is different from Item 70, Recommended Grant, amount.

Also use B, F, H, and M to issue additional amounts for months in which benefits have already been produced. These codes identify why the additional amount is requested.

Use these codes to issue a benefit for the current or previous month when releasing hold with Code 0 or 7 in Item 142.

O — Retroactive and/or current month's benefit when releasing a case from hold with release Code 0or 7 in Item 142. Use for a benefit amount equal to the grant amount to be printed in Item 70.

P — Budgeting process requires different payment month benefits. Enter Code 1 in Item 179. Use for a benefit amount different than the amount to be printed in Item 70.

R — (State office use only.) Identifies on the history file benefits produced when release Code 8or 9 is used to release a case from hold. These benefits will always be for the recommended grant amount previously on file, not a recommended grant amount changed at the time the hold is released on Form H1000-B and Form H1000-C.

T — Transfer from TP 07, 20 , 29, or 37 to TP 01 or 61 (Form H1000-B and Form H1000-C use only).Use to issue a benefit of the same amount for the previous month, if needed. The advisor must ensure that the benefit amount requested is equal to the new grant amount that is printed in Item 70. Use Form H1008 to request a benefit for a different amount or an earlier month.

SNAP

Enter one of the following codes to indicate the type of benefit requested:

Full Regular Ongoing Benefits or Replacement of These Benefits

A — Initial benefit (regular ongoing benefit).

E — Initial expedited benefit issued through

- SAVERR to meet timeliness requirements, or
- the ATA and reported timely in Section XI.

Also use for the second month on an expedited case when issuing the second month's benefits as a combined allotment and the first month's benefit cannot be issued because it prorates to less than $10.

H — Use to issue a benefit through SAVERR as a priority issuance to meet timeliness for a hearing officer decision. Do not use when timeliness can be met using another applicable code.

L — Restored full month's benefit for a past month.

1 — Use only to clear discrepancy report RF-07E-1, generated because the benefit was issued via the ATA and was not reported timely in Section XI. On inquiry, an issuance coded E by the advisor displays as a Code 1 if the benefit was issued via the ATA.

2 — Priority benefits issued through

- SAVERR to meet non-expedited application timeline requirements, or

- the ATA to meet non-expedited application timeliness requirements and reported timely in Section XI.

3 — Use only to clear discrepancy report RF-07E-1, generated because the benefit was issued via the ATA and was not reported timely in Section XI. On inquiry, an issuance coded 2 by the advisor displays as Code 3 if the benefit was issued via the ATA.

All issuances coded A, E, 2, or L in Item 180 must balance using Items 184, 185, 186 (if applicable), and 187.

Potential Item 180 code combinations for applicants receiving combined allotments are:

First Month Code	Second Month Code
E (Expedited)	2
2 (Timely)	2
No issuance*	E
A (Regular)	A
No issuance*	2
No issuance*	A
1 (Expedited-ATA; reported untimely)	3
3 (Expedited-ATA; reported untimely)	3
No issuance*	1
No issuance	3

*1st month not issued due to proration

Additional Benefits for a Month

C — Supplemental benefits. Use when providing benefits in addition to initial benefits for the current month or following month if submitting Form H1000-A, Form H1000-B and Form H1000-C after cutoff.

D — Restoration benefits. Use when restoring partial benefits for a past month.

F — Supplemental or restoration benefits. Use when providing additional benefits for a month in which the household has already received one issuance coded C and/or one coded D.

P — Restore an erroneously expunged EBT benefit.

Destroyed Food

T — Replacement of destroyed food, that was purchased with SNAP benefits.

Historical Information: State office also uses this code to replace CCDMIs that are lost/stolen within the postal system. No longer in use effective April 1, 2004.

Every month must have an uncanceled A, E, 1, 2, 3, or L before an issuance coded C, D, F, P, or Tin Item 180 can be processed. To replace a canceled issuance, always use the same code in Item 180.

Only one type issuance Code C or D is allowed per month. Codes C and D issuances are allowed for the same month. Code C cannot be used for month already having a type code L issuance. Code F cannot be used unless type code C or D has been issued for the month.

Advisor entered cancellation

G — Use to cancel EBT benefit because the household has moved out of state. Use code N in Item 179.

State Office-entered

4 — Historical Information: CCDMI mailed out of state as a result of converting EBT benefits to coupons. No longer in use effective April 1, 2004.

5 — Historical Information: Benefits placed back in an EBT account after a CCDMI was returned and cancelled. No longer in use effective April 1, 2004.

These codes do not appear on Form H1000-B. These are in the benefit history file that is available through inquiry.

Item 181: ATP/Benefit No.

TANF and SNAP

Issuance numbers issued via EBT have two leading alpha characters (**Example:** AA12345).

TANF

Make no entry. SAVERR assigns issuance numbers.

SNAP

Make no entry if requesting an issuance or reporting an ATA issuance timely.

SAVERR assigns an issuance number when authorizing an issuance or when the EBT system reports an issuance.

Priority Issuance Numbers:

- Issuance numbers beginning with ZX indicate priority issuances processed via the ATA that were not reported on Form H1000-A, Form H1000-B and Form H1000-C within five days.
- A code X after an issuance number indicates SAVERR sent the benefit record to the vendor system as a priority issuance. SAVERR sends benefits as priority issuances only if the advisor uses code E in Item 179 and code E, H, or 2 in Item 180.

Item 182: Issue Date

TANF

Enter only on Form H1000-B and Form H1000-C when requesting a prorated benefit resulting from the transfer of a case from TP 07, 20, 29, or 37 to TP 01 or 61.

SNAP

Enter the date benefits were issued if canceling an issuance.

Enter the issue date if reporting an ATA issuance untimely to clear an RF-07/37E-1.

In the Issue Date (ISSUE DT) column, SAVERR inquiry displays an asterisk (*) for the second month's benefit of a combined allotment if it is issued before cutoff of the application month. This information does not appear on Form H1000-B. It is in the benefit history file that is available through inquiry.

Item 183: Benefit Month

TANF and SNAP

Enter the month and year for which the benefits are requested. Use a separate line for each benefit month entered.

SNAP

Historical Information: In the EFF column, SAVERR inquiry displays the date a CCDMI was processed instead of the benefit month. This information does not appear on Form H1000-B. It is in the benefit history file that is available through inquiry. No longer in use effective April 1, 2004.

TP 55 and 30

Enter the month and year for the prior coverage month in which a case is eligible or potentially eligible.

Item 184: Net Income

TANF, SNAP, TP 55 and 30

Enter the whole dollar amount of net income that applies to the benefit month in Item 183.

Item 185: Benefit Amount

TANF

Enter the benefit amount requested.

SNAP

Enter the amount of the benefit being issued. If recouping $8 from a $10 allotment, enter $2.00

TP 55 and 30

Enter the spend down amount for that month. Enter 0 if there is no spend down.

Item 186: Other Data (Initial Month and Code)

TANF

When issuing a benefit (prorated, full, or supplemental) in Section XI that is reduced because of a financial penalty, enter the penalty amount and penalty code in Item 186. If the benefit is reduced because of multiple penalties, enter the amount and Code U (multiple penalties). Enter the adjusted benefit amount (the benefit amount minus the penalty amount) in Item 185.

If a supplement is issued because a penalty was imposed in error, enter Code F in Item 180 and code (supplemental restored benefit) in Item 179.

SNAP

Do not recoup on a Section XI issuance or a prorated initial month's benefits. Enter the appropriate initial month code in this item and record the dollar amount.

If you are not prorating the initial month's benefits, leave this item blank. Make the following entries if you are prorating benefits:

Issuance Type	Cents Field	Dollar Field
SAVERR or ATA issuance reported timely on Form H1000-A, Form H1000-B and Form H1000-C.	P	No entry.
ATA issuance reported untimely (code S entered in Item 179).	P	Enter the amount subtracted from the whole monthly benefit because of proration. **Example:** A $100 allotment prorates to $60. Enter $60 in Item 185, P in Item 186 cents field, and $40 in the dollar field.

For all issuances coded C, D, F, H, P, or T in Item 180, enter in the cents field the range code below that corresponds to the issuance amount in Item 185. Do not make an entry in the dollar field.

Range Code	Issuance Dollar Amount	Range Code	Issuance Dollar Amount
A	$1 - 49	H	$350 - 399
B	50 - 99	J	400 - 449
C	100 - 149	K	450 - 499
D	150 - 199	L	500 - 549
E	200 - 249	M	550 - 599
F	250 - 299	X	600 or over
G	300 - 349	-	

These codes are not needed for benefits coded A, E, L, or 2 since these type of benefits must correspond to entries in Item 184, Net Income and Item 187, Household Size.

Item 187: H.H. No. (Household Number)

TANF

Enter the household composition for the benefit requested.

Digit	Number of individuals with status in group Code
1st	7 and 8. The maximum number is two. If none, enter 0.
2nd and 3rd	5. If none, enter 00. If there are less than ten members with SIG 5, enter 0 for the 2nd digit and number SIGs 5 in the 3rd digit.

Example: One adult and three children – 103.

SNAP

Enter the number of people in the SNAP household whose benefits are included in the issuance reported.

TP 55 and 30

Enter the household composition for the month.

Digit	No. of
1st	adults in the budget group.
2nd and 3rd	children in the budget group. Include the unborn child in this entry for cases with an 01 entry in Item 128, base plan.

For budget group with less than 10 children, enter 0 for the second digit.

These entries must correspond with Items 184 and 185.

C—520.12 Section XII

Revision 02-3; Effective April 1, 2002

All Programs

SAVERR completes this section to report the status of a denied application, the case status and the form effective date.

Item: (App. Code) (Action Code) (Action Date)

SNAP

SAVERR prints the denied application information in this section. This information appears only in Section XII, and not in Items 79, 91, and 92.

Item: Case Status

All Programs

This item shows the current status of the case: active, denied, or hold.

Item: Form Effective Date

All Programs

This item shows the form effective date of the previously submitted Form H1000-A, Form H1000-B and Form H1000-C.

On Form H1000-B and H1000-C with Sequence 02, the form effective date is the first of the month that the input document was entered on SAVERR.

On Form H1000-B and Form H1000-C with sequences 03 and above, the form effective date is the date the action reported on the previous Forms H1000-B and Form H1000-C becomes effective according the SAVERR cutoff cycles.

C—520.13 Section XIII

Revision 02-3; Effective April 1, 2002

TANF and SNAP

SAVERR records on the Form H1000-B turnaround the monthly benefit issuance history for the current and past 11 months.

TP 55 and 30 with Base Plan of 55

SAVERR prints the three months prior spend down on Form H1000-B turnaround.

Item: ISS/CAN/Results

TANF

This item records the authorization code from Item 180 and the benefit amount from Item 185.

SNAP

This item records the advisor entries from Items 179 and 185.

Item: Date

TANF

This item lists the month of eligibility for which the benefit was issued.

SNAP

This item records the month and year for which benefits are authorized (benefit month).

Item: Issued/No.

TANF

This item lists the number of issuances for the month of eligibility.

SNAP

This item records the number of issuances the household is issued for the month.

Item: Issued/Persons

SNAP

This item records the household size listed on the last benefit issued for the month.

Item: Issued/Amounts

TANF

This item lists the amount of benefits issued for the month.

SNAP

This item records the household's cumulative benefit allotment, including supplemental benefits and replacement issuances, less any cancelled benefits.

Item: Redeemed/No.

SNAP

This item records the cumulative number of issuances for the household.

Item: Redeemed/Persons

SNAP

This item is not used.

Item: Redeemed/Amount

SNAP

This item is a record of the amount of benefits issued monthly.

Item: CD

TANF

The code in this column indicates deductions made from recognizable needs. (R = Recoupment deduction)

SNAP

This item records the type of the last issuance processed in the month.

C—520.14 Section XIV, Items 188 - 191

Revision 02-3; Effective April 1, 2002

Item 188: Signature

All Programs

The advisor completing Form H1000-A, Form H1000-B and Form H1000-C signs and enters his unit number in this space.

Item 189: Date Signed

All Programs

Enter the date Form H1000-A, Form H1000-B or Form H1000-C is signed.

TANF

Exception: When certifying a TANF application, enter the certification date. This should be the date entered on the TANF worksheet. SAVERR prorates benefits for the first month of eligibility from this date or the 30th day after the file date, whichever is earlier.

Item 190: EMP No.

All Programs

Enter the employee number of staff signing Form H1000-A, Form H1000-B and Form H1000-C.

Item 191: TP Only

All Programs

Data Communications Unit use only. Make no entry.

Medical Programs

When the record of case action is received, the advisor or clerical reviewer edits, initials, and dates the form. If the turnaround document contains an error or warning message, the clerical reviewer must not initial and file it, but must immediately send it to the advisor.

C-530, Form H1000-C, Secondary Client Input Instructions

Body

Revision 05-4; Effective August 1, 2005

TANF and SNAP

Use Form H1000-C to enter start and end dates for PRA penalties and good cause. Form H1000-A and Form H1000-B must be submitted with Form H1000-C, but Form H1000-C is not always required when submitting Form H1000-A and Form H1000-B. SAVERR does not produce a turnaround for Form H1000-C.

C—530.1 Section I, Items 01 - 07

Revision 08-4; Effective October 1, 2008

Item 01: App. or Case No.

TANF and SNAP

Enter the application or case number.

Item 03: Seq. No.

TANF and SNAP

Enter the same sequence number from Form H1000-A and Form H1000-B.

Item 04: Pg. No.

TANF and SNAP

Enter the same page number the individual is listed on Form H1000-A and Form H1000-B.

Item 06: BJN

TANF and SNAP

Enter the employee's BJN.

Item 07: Mail Code

TANF and SNAP

Enter the office mail code.

Item 09: Case Name

TANF and SNAP

Enter the same case name from Form H1000-A and Form H1000-B.

C—530.2 Section II, Items 201 - 213

Revision 05-5; Effective October 1, 2005

Item 201: PAR. SKILLS

TANF

When an individual is referred or has completed Parenting Skills training, enter code

R — Eligibility referred the individual to parenting skills training, or

C — Eligibility verified that the individual completed parenting skills training.

SAVERR stores Code R or C on Client Screen A, Welfare Reform Data, under Parenting Skills status. In addition, the status of J appears in this SAVERR field when the Choices system verified that the individual completed parenting skills training as a Choices component.

Items 202, 205, 208, and 211: TYPE

TANF

When starting or ending a penalty or good cause, enter the following codes in these Items

Penalty Codes

Code or Action	Definition
T	Third or subsequent noncooperation with Choices
S	Second noncooperation with Choices
F	First Noncooperation with Choices
C	Child Support
V	Voluntary Quit
E	Texas Health Steps
G	Immunizations
M	School Attendance - child
P	School Attendance - minor parent
D	Alcohol or Drugs
U	Unidentifiable penalty - Use this code when making Section XI entries only and the benefit is being reduced by more than one penalty.

Good Cause Codes

Code or Action	Definition
1	Individual is on an alternate schedule for immunizations
2	Good cause for immunizations due to medical reasons
3	Good cause for immunizations due to conscientious objection
4	Grace period
6	Good cause for noncooperation with Texas Health Steps
7	Good cause for noncooperation with Parenting Skills Training

Note: Good cause Code 5 is sent through the Choices automated system.

Items 203, 206, 209, and 212: Start

TANF

Enter the month and year the penalty starts. At application, start a child support or voluntary quit penalty beginning the application month.

On incomplete and complete reviews, the start date cannot be earlier than three months before the current cutoff month or later than the next SAVERR effective month.

Items 204, 207, 210, and 213: End

TANF

Enter the month and year the penalty ends.

SAVERR does not allow entry of future end date. The end date cannot be later than the SAVERR effective month.

C—530.3 Section III, Items 214 - 215

Revision 09-4; Effective October 1, 2009

Item 214: FIC (R/E) (Finger Image Code)

TANF and SNAP

Enter finger image codes for required individuals at application and at complete review/recertification, including simultaneous open and close transactions. Finger image codes are not required on denials or Temporary Assistance for Needy Families (TANF) complete reviews with a future action code of a denial.

If the correct finger image code is not already on the System for Applications, Verifications, Eligibility Reports and Referral (SAVERR), enter a finger image code for each household member who is:

- age 18 or older as of the interview date;
- a minor parent (secondary SIG L) on a TANF case with a dependent child on the same case; or

- a minor head of household (SIG A) on a Supplemental Nutrition Assistance Program (SNAP) case.

Enter one of the following finger **imaging codes**:

Imaging Code	Definition
Y	All available images have been taken.
Z	One image has been taken (**Note:** This includes a finger image that Lone Star Image System (LSIS) determines to be temporarily unavailable because of low quality.)

Enter one of the following **exemption codes**:

Exemption Code	Definition
A	Appeal pending (TANF related)
B	Low quality image, physically unable to image or equipment failure
C	Certified out of office or unable to travel to the LSIS site to be imaged
D	Undue burden for disabled individual
E	Undue burden for elderly individual
F	Disqualified (SNAP only) **Note:** If SAVERR has no finger imaging code and Form H1000-C, Secondary Client Input, has no entry, the finger imaging code defaults to F for individuals with SIG G, or SIG K or T when the individual is over 18.

On expedited SNAP cases for required members:

- present at the interview, enter the appropriate
  - finger image code and vendor unique number (VUN); or
  - finger imaging exemption code.
- not present at the interview, allow Code C until the next recertification or reapplication.

Automated Changes

The advisor cannot change Codes I or Y on Form H1000-C. SAVERR performs this automated conversion as described in the following chart.

If the individual's status changes from ...	and SAVERR has code ...	then SAVERR ...
inactive to active	I	• changes the code to Y, and • sends a message to LSIS to remove the archive date.
active to inactive	Y	• changes the code to I, and • sends a message to LSIS to set the archive date.

SAVERR also sends a message to LSIS to set the archive date on inactive individual records with Code Z, but does not change the code.

SAVERR automatically deletes the finger Code I or Z when LSIS notifies SAVERR that it purged the finger image record. The LSIS purges the finger image record after the individual is inactive for 12 months.

Changing, Correcting or Deleting Finger Image Codes

Finger image exemption codes remain on SAVERR until it purges the individual record.

If the advisor needs to change ...	to ...	then ...
Code Z	Code Y,	enter the new code on Form H1000-C.
an exemption code	Code Y,	enter the new code and VUN, on Form H1000-C.
an exemption code	another exemption code,	enter the new code on Form H1000-C.

If the advisor needs to change ...	to ...	then ...
Codes Y or Z	an exemption code,	• deletes the Y or Z through the force change process using Form H1075, Welfare Reform Force Change Request, for TANF individuals or Form H1074, SNAP Force Change Request, for food benefit individuals, and • enter the new code on Form H1000-C after the forced change processes.
Code I	an exemption code	• follow the procedures listed above for Codes Y and Z, or • allow the vendor's automated purge process to delete the code if the LSIS record is approaching its archive date.

Item 215: Vendor's Unique Number

TANF and SNAP

If the entry in Item 214 is Y or Z, enter the nine-digit VUN.

The VUN contains a "check digit," an automated aid for validating data. If the check digit indicates the advisor did not enter the VUN correctly, Form H1000-C will not process.

SAVERR does not store the VUN, but uses it to associate the SAVERR client number with the finger image record on the vendor's system.

C—530.4 Section IV, Items 216 - 223

Revision 07-4; Effective October 1, 2007

Item 216: ADD

SNAP

Enter the code(s) to indicate that an individual is being disqualified for one or more of the following reasons, even if the disqualification results in case denial. Once entered, these codes remain on the System for Applications, Verifications, Eligibility Reports and Referral (SAVERR) until removed by an entry in Item 217.

Code or Action	Definition
B	Ineligible alien without a U.S. Citizenship and Immigration Services (USCIS) document
C	Ineligible aliens with USCIS document
D	Felony drug conviction
F	First offense failure to comply with Employment Services Program (ESP) requirements (employment and training/voluntary quit/reducing work hours to less than 30)
J	Fugitive
N	Failure to meet the Social Security number (SSN) requirement
S	Second offense failure to comply with ESP requirements
T	Third or subsequent offense failure to comply with ESP requirements
W	Failure to comply with the 18-50 work requirement

Note: Send Form H1074, SNAP Force Change Request, to correct SAVERR information on:

- active individuals to delete the drug disqualification code; or
- denied individuals to add or delete a disqualification code or change the employment and training/voluntary quit counter.

Item 217: Remove

SNAP

Enter a code below to remove a code, end a specific type of disqualification or change a Supplemental Nutrition Assistance Program (SNAP) time-limited benefit code. Enter one of the following codes to indicate the action needed.

Code or Action	Definition
1	Delete the first countable month
2	Delete the second countable month
3	Delete the third countable month
4	Delete the fourth countable month (first month of second three month period)
B	End the ineligible alien (undoc) disqualification
C	End the ineligible alien (doc) disqualification
F	End the first offense SNAP ESP disqualification
J	End the fugitive disqualification
L	Subtract one offense from the ESP offense counter (when entering code L, do not enter Code F, S or T in Item 216 on the same Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action and Form H1000-C, Secondary Client Input, transaction) **N** — End of the SSN disqualification
N	End of the SSN disqualification
S	End the second offense SNAP ESP disqualification
T	End the third offense SNAP ESP disqualification
W	End the 18-50 work requirement disqualification

Items 218 - 223

SNAP

Make entries in these fields to report that HHSC has authorized a SNAP benefit for accountable month of the initial or second three-month period of time-limited benefits in a 36-month period for an individual age 18-50. Make entries of Code(s) 1-4 in Items 218 and the corresponding month(s) in Item 219.

Items 220-223 can be used on the same Form H1000-A,Form H1000-B and Form H1000-C transaction when necessary to simultaneously report up to three months of countable issuances. If the advisor needs to report four months simultaneously, the fourth month (first month of second three-month period) must be reported on a subsequent Form H1000-C.

SAVERR does not automatically update the months of countable time-limited SNAP benefits received by an individual age 18-50. The advisor must update SAVERR each time when submitting Form H1000-A, Form H1000-B and Form H1000-C.

Staff do not have to enter the last month of the 36-month period. SAVERR computes it based on the months entered by the advisor as the first countable month of the initial three-month period of time-limited benefits, and displays it on inquiry.

On the same Form H1000-C, staff can delete months using Item 217 and enter corrected months in Items 218-223.

Item 218: Code (Countable Month Code)

SNAP

Enter one of the following codes and a corresponding month in Item 219:

Code or Action	Definition
1	Benefit authorized for the first month of the initial three-month period
2	Benefit authorized for the second month of the initial three-month period
3	Benefit authorized for the third month of the initial three-month period
4	Benefit authorized for the first month of the second three-month period

Item 219: Month (Countable Month MMYYYY)

SNAP

Enter the month and year corresponding to the code entered in Item 218. The month cannot be greater than the SAVERR effective month.

Item 220: Code (Countable Month Code)

SNAP

If more than one month needs to be reported on the same Form H1000-A, Form H1000-B and Form H1000-C, enter the appropriate code (2, 3 or 4) to indicate that HHSC has authorized a SNAP benefit for a second, third, or fourth (first month of second three-month period) countable month. Enter a corresponding code in Item 221.

Item 221: Month (Countable Month MMYYYY)

SNAP

Enter the month and year corresponding to the code entered in Item 220. The month cannot be greater than the SAVERR effective month.

Item 222: Code (Countable Month Code)

SNAP

If more than two months needs to be reported on the same Form H1000-A, Form H1000-B, Form H1000-C, enter the appropriate Code 3 or 4, to indicate that HHSC has authorized a SNAP benefit for a third or fourth countable month. Enter the corresponding month in Item 223.

Item 223: Month (Countable Month MMYYYY)

SNAP

Enter the month and year corresponding to the code entered in Item 222. The month cannot be greater than the SAVERR effective month.

C—530.5 Section V

Revision 02-3; Effective April 1, 2002

Item 190: Emp. No.

TANF and SNAP

Enter employee number of staff member completing form.

C—540 Code Summary

Revision 08-4; Effective October 1, 2008

TANF and SNAP

This section contains a Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action, and Form H1000-C, Secondary Client Input, instructions code summary.

Item 02: Category

TANF

Code or Action	Definition
2	TANF
5	Refugee Cash Assistance (RCA)

SNAP

Code or Action	Definition
6	Public Assistance (PA) SNAP Case
8	Refugee, PA SNAP
9	Non-PA SNAP Case

Item 03: Sequence No. (SEQ)

TANF and SNAP

Code or Action	Definition
Y	Yes

Item 27: Modifier (M)

TANF

Code or Action	Definition
P	Protective Payee
R	Representative Payee

SNAP

Code or Action	Definition
I	Authorized representative (AR) is a member of household (under the same roof).
O	AR is not a member of household (not under the same roof).
F	AR is an employee of a drug and alcohol treatment or group living arrangement facility.

Item 28: Indicator Code

TANF

Code or Action	Definition
M	Incapacity

TANF-UP

Code or Action	Definition
U	(system entered when TP 61 transfers to TP 07, 20 or 37)

SNAP

Code or Action	Definition
1	Streamlined reporting (SR) household with total gross monthly income that is less than or equal to 130% of the Federal Poverty Income Limits (FPIL).
2	SR household with total gross monthly income that is greater than 130% FPIL.
3	Non-SR household.

Item 32: Client Number

TANF and SNAP

Code or Action	Definition
2	Check for an existing number.

Item 35: Sex

TANF and SNAP

Code or Action	Definition
M	Male
F	Female

Item 36: Race

TANF and SNAP

Code or Action	Definition
1	White
2	Black
3	Hispanic
4	American Indian or Alaskan Native
5	Asian or Pacific Islander (includes Indochinese)
6	Computer entered code indicating inappropriate or omitted code. Must be corrected.

Item 39: Education or Service Code

TANF and SNAP

Code or Action	Definition
1	First Grade
2	Second Grade
3	Third Grade
4	Fourth Grade
5	Fifth Grade
6	Sixth Grade
7	Seventh Grade
8	Eighth Grade
9	Ninth Grade
A	Tenth Grade
B	Eleventh Grade
C	High School Graduate or completed general equivalency diploma
E	Attending college or completed some college but has not graduated from a four-year college
F	Graduate of a four-year college
N	No formal education

Item 40: Status in Group

TANF

Primary Codes

Code or Action	Definition	If the child receives ...	then enter SIG Code
2	Disqualified or ineligible child or second parent		
3	Noncertified child: Identifies the only deprived child of the certified caretaker or second parent	• SSI • Foster Care Payments • Adoption Assistance payments	• 3 • 3F • 3A
5	Certified Child		
7	Second Parent		
8	Caretaker		
9	Payee		
0	Case Name Only		

Secondary Codes

Code or Action	Definition
G	Reached End of Time Limit
H	Eligible Refugee
I	Ineligible Child
K	Child of a Minor Child
L	Minor Parent with a Dependent Child

Code or Action	Definition
M	Eligible Only for Three Months Prior Medical Assistance
N	Ineligible for Retroactive Medical Assistance and Current Assistance
P	Private Health Insurance
Q	Proof of THSteps Screening
R	HHSC Employee
S	Alien with Acceptable Alien Status
T	Ineligible Alien
U	Ineligible - No Citizenship Proof
V	Living in Nursing Home
W	Disqualified Child
X	Deceased
Y	Disqualified Second Parent
Z	Migrant

SNAP

Head of Household Codes

Code or Action	Definition
A	Household head
G	Household head is nonmember
GK	Head of household disqualified for a reason other than an IPV
GT	Head of household is disqualified for intentional program violation (IPV)

Other Codes

Code or Action	Definition
A	Child (SIG 5 or 5L)
B	Caretaker or second parent, age 18 or younger attending school
C	Caring for an ill or disabled child in the household, even if the child is not a member of the certified group
E	Unable to work due to a disability expected to last more than 180 days
F	60 years of age or older
G	Caring for a child (SIG 2, 3, or 5) under age 1
H	Presence required in home due to illness or incapacity of another adult household member and the disability is expected to last more than 180 days
J	Not subject to participation – not a certified TANF individual
K	Pending during appeal of denial or disqualification
L	County Hardship Exemption
M	Mandatory registrant
N	Employment Hardship Exemptions
P	Mandatory registrant employed or self-employed 30 or more hours per week and earning at least $700 a month
Q	Severe Personal Hardship Exemption
R	Caring for child under age 1 who is not listed on Form H1000-A, Form H1000-B and Form H1000-C
T	Pregnant and unable to work
U	A single grandparent age 50 or over caring for a child under age three
V	An SSI recipient parent.
W	Identifies a individual who noncomplies with the Choices program
X	A parent who has exhausted state time limits.
Y	A parent who is disqualified due to third party resource (TPR) requirements, Social Security number requirements, intentional program violation, failure to report a child's absence, being a fugitive, having a felony drug conviction, failure to cooperate with Quality Control or noncompliance with the unmarried minor parent domicile requirement.

B — Student

C — ABAWD not meeting 18-50 work requirement

D — ABAWD meeting 18-50 work requirement

F — Resident of drug and alcohol treatment/group living arrangement facility

H — Eligible Refugee

K — Disqualified for a reason other than IPV

M — Migrant, out of work stream

R — HHSC Employee

S — Eligible Alien (not a refugee)

T — Disqualified for Intentional Program Violation

U — Seasonal Farm Worker

W — Migrant, in work stream

Item 41: Employment Services/Work Registration

TANF

Code or Action	Definition
A	Child (SIG 5 or 5L)
B	Caretaker or second parent, age 18 or younger attending school
C	Caring for an ill or disabled child in the household, even if the child is not a member of the certified group
E	Unable to work due to a disability expected to last more than 180 days
F	60 years of age or older
G	Caring for a child (SIG 2, 3, or 5) under age 1
H	Presence required in home due to illness or incapacity of another adult household member and the disability is expected to last more than 180 days
J	Not subject to participation – not a certified TANF individual
K	Pending during appeal of denial or disqualification
L	County Hardship Exemption
M	Mandatory registrant
N	Employment Hardship Exemptions
P	Mandatory registrant employed or self-employed 30 or more hours per week and earning at least $700 a month
Q	Severe Personal Hardship Exemption
R	Caring for child under age 1 who is not listed on Form H1000-A, Form H1000-B and Form H1000-C
T	Pregnant and unable to work
U	A single grandparent age 50 or over caring for a child under age three
V	An SSI recipient parent.
W	Identifies a individual who noncomplies with the Choices program
X	A parent who has exhausted state time limits.
Y	A parent who is disqualified due to third party resource (TPR) requirements, Social Security number requirements, intentional program violation, failure to report a child's absence, being a fugitive, having a felony drug conviction, failure to cooperate with Quality Control or noncompliance with the unmarried minor parent domicile requirement.

SNAP

Code or Action	Definition
A	Child age 16 years of age or child age 16 or 17 who attends school at least half-time, or is not the head of household
D	Three to nine-months pregnant
E	Physically or mentally unfit for employment
F	60 years of age or older
G	Caring for a child under age six
H	Presence in home required for care of an incapacitated person

Code or Action	Definition
J	Person in drug addiction or alcoholic treatment and rehabilitation program
N	Receiving or applying for unemployment compensation
P	Employed or self-employed 30 hours or more a week
Q	Individual resides in a Choices county and is mandatory or has volunteered for TANF employment services
R	Registered again, after previously serving the E&T noncompliance penalty period
S	Student exemption (age 18 or older/in a training program)
T	Disqualified household member or nonmember head of household
U	Primary wage earner failed to comply with SNAP employment services
2	Registered, employed less than 30 hours a week
3	Registered, not working
4	Registered, job attached (temporarily laid off)
5	Registration postponed, expedited service

Item 42A: Type Income

TANF and SNAP

Code or Action	Definition
A	Veteran's Administration (VA) benefits
C	Unemployment Insurance benefits
P	Pension benefits (other than RSDI, SSI, VA or RR)
M	Combination of unemployment benefits with benefits from a pension, VA, or both
W	Combined income from VA and a pension

Item 49: Disqualification Code (Intentional Program Violation)

SNAP

Code or Action	Definition
1st digit	**T** – Administrative disqualification for offense which occurred prior to September 22, 1996 **S** – Administrative disqualification for offense which occurred on or after September 22, 1996, or disqualification for conviction due to trafficking **C** – Court-ordered disqualification **M** – Disqualification due to receipt of multiple benefits in one month.
2nd digit	**1** – 1st disqualification **2** – 2nd disqualification **3** – 3rd disqualification **4** – permanent disqualification for trafficking in SNAP benefits or program access devices of $500 or more.
3rd – 6th digits	**MMYY** – last month of disqualification **PERM** – disqualification permanent

Item 50: Error Messages

TANF and SNAP

The following format is used for all error messages: AAABBCCC

Error Message	Definition
AAA	Form Item number 001-191; client Items 32-50 will be shown A32-K32, through K50. When a client Item is shown without line indicator, 032-050, then the comparison of all entries within that Item caused the error.
BB	One of the following two-digit qualifiers: • EC – ERROR CODE NUMBER"CCC" • EQ – EQUAL • GE – GREATER THAN OR EQUAL • GT– GREATER THAN

Error Message	Definition
	• LE – LESS THAN OR EQUAL • LT – LESS THAN • NA – NOT ALLOWABLE WITH THE ENTRY OR LACK OF ENTRY IN "CCC" • NE – NOT EQUAL
CCC	Form Item number 001-191; or error code number 300-999; or one of the following "KEY" words: • ALP – ALPHABETIC • BLK – BLANK • CUR – CURRENT PROCESS MONTH • DAT – VALID DATE • FIL – VALUE ALREADY ON FILE • N-3 – today minus 3 months • N-6 – today minus 6months • N12 – today minus 12 months • N24 – today minus 24 months • N45 – today minus 45 days • NAM – NAME FORMAT • NOW – PROCESS DATE OF FORM • NUM – NUMERIC • NXT – NEXT PROCESS MONTH • VAL – VALID

Error Codes

Code or Action	Definition
300	Either the first digit of application number is not A or the last eight digits are not numeric
301	By changing the A of the application number to zero, it was found that a case already on file has been assigned that number.
304	Application already disposed
305	BJN was incorrect
307	The case or individual indicated is already active in the same program area for the benefit period requested.
308	The client number entered cannot be reassigned due to a mismatch of client information.
309	Multiple entries for this Item contained the same value.
320	A SNAP denial cannot precede a benefit issuance month.
321	The ATA issuance exceeded the maximum allotment for household size.
400	The individual's SSI coverage was changed to **Suspense**
402	Hierarchy of individual information prevented the use of the client entries on the transaction.
403	The entry made in Adjusted Gross Income is zero. Determine if the correct income was entered.
404	Valid entries for case number reassignment are required.
500	The rejection of this attempted denial caused the case to be placed on hold.

Item 78: Type of Review

SNAP

Code or Action	Definition
C	Complete review
I	Incomplete review
N	Non-review activity (case maintenance)

Item 79: Application Codes

SNAP

Code or Action	Definition
First Digit – Application Type	**1** – Eligibility Determination **2** – Redetermination **3** – Application reopened after denial
Second digit	Enter X
Third digit – Number of Months	**0** – All initial applications, reapplications within 30 days from previous application, or later applications within 30 days after the end of the previous certification period. **1-8** – Enter the number of months, as appropriate, since the last application or certification period. **9** – Nine months or longer since the last application or certification period.

Item 84: AID

SNAP

Code or Action	Definition
1	NPA Only
2	NPA Mixed
3	TANF-PA
5	Refugee, PA

Item 85: Test (Income Test or Shelter Deduction Identifier)

SNAP

Code or Action	Definition
B	Gross and net income tests with capped shelter deduction.
C	Categorically eligible household with capped shelter deduction.
E	Gross and net income test and uncapped shelter deduction. Use this code only if the member who is entitled to uncapped shelter costs is disqualified for intentional program violation.
M	Net test only, uncapped shelter deduction.
T	Categorically eligible household with uncapped shelter deduction. **Note:** This code is also used in situations where a household member, disqualified for any reason, is the only elderly or disabled member.

Item 87: NON (Non H/H Members)

SNAP

Code or Action	Definition
A	Attendant
B	Boarders
C	Ineligible alien
D	Ineligible student
E	Any combination of two or more of A, B, C, or D

Item 89: SSI

SNAP

Code or Action	Definition
X	Every household member receives SSI

Item 90: Util (Utility Expense Code)

SNAP

Code or Action	Definition
1	Household claiming the Standard Utility Allowance.

Code or Action	Definition
2	Household claiming telephone standard only, or telephone standard plus actual utilities.
3	Household claiming actual utility costs only (even if some members are disqualified).
4	Household without utility costs.
5	Two households live together and share the standard utility allowance.
6	Households claiming the standard utility allowance with member(s) disqualified for not meeting the citizenship, 18-50 work, and or SSN requirements.
7	All other proration situations. A combination of households described in Codes 5, 6, B, and C, a prorated telephone standard, and all other situations in which the utility allowance is prorated (such as a proration involving three or more households, or more than one disqualified member).
8	Household claiming the homeless shelter standard.
9	Household claiming the homeless shelter standard with one member who is disqualified for not meeting the citizenship, 18-50 work or SSN requirements.
A	Households claiming the basic utility allowance.
B	Two households live together and share the basic utility allowance.
C	Households claiming the basic utility allowance with member(s) disqualified for not meeting the citizenship, 18-50 work or SSN requirement.

Codes 1, 2, 3, 4, 5, 7, A, and B are allowed for household containing member(s) disqualified for an intentional program violation, felony drug conviction, E&T non-compliance, and/or being a fugitive.

Codes 3, 4, 6, 7, 9, and C are allowed for households containing member(s) disqualified for not meeting the citizenship requirement, 18-50 work requirement, or SSN requirement. Also, these codes are allowed for household containing member(s) disqualified for an intentional program violation, felony drug conviction, E&T non-compliance, and/or being a fugitive **and** member(s) disqualified for citizenship, 18-50 work requirement, and/or SSN requirements. **Note:** Utility, homeless, and telephone standards, if used, are prorated for these kinds of disqualifications.

Item 91: Action Code

SNAP

See C-221, Denial Codes.

Item 95: Code or Hold Date

SNAP

Hold Codes

Code or Action	Definition
2	Hold benefits
A	Form H1000-B has fatal error not cleared by cutoff
Z	Dormant EBT account (state office use)

Release Codes

Code or Action	Definition
0	Do not hold future benefits.

Item 101: Prepared Meals Services Code

SNAP

Code or Action	Definition
C	SSI or elderly member authorized to purchase from communal dining facilities, meal delivery service, or contracted restaurant
E	Homeless and either elderly or SSI recipient; authorized to purchase from every service (communal dining, meal delivery services, or homeless meal providers and contracted restaurants)
H	Authorized to purchase from homeless meal providers/contracted restaurants

Code or Action	Definition
M	Household or disabled member authorized to purchase from meal delivery services

Item 104: Special Review Code

SNAP

Enter the appropriate code to show the type of special review needed.

Code or Action	Definition
0	State office assigned
1	Employment Services or Work Registration
2	School Attendance
3	Reserved
4	Management
5	Income or Expense changes anticipated
6	Living arrangement change anticipated
7	Medical review
8	Household change anticipated
9	Other

Item 127 Type Program

TANF

Code or Action	Definition
01	Cash and medical assistance
04	Medical Assistance Only – Deceased
07	12 or 18 months medical assistance only
11	Three months prior medical assistance only not currently eligible
20	Medical assistance only – Child Support
37	12 or 18 months medical assistance only
61	TANF-UP cash and medical assistance
71	OTTANF – One parent household
72	OTTANF – Two parent household

Item 131: Type Review

TANF

Code or Action	Definition
C	Complete review
I	Incomplete review
N	Non-review activity (case maintenance)

Item 132: Action Code

TANF

See C-200 for Item 132 Codes.

Item 138: (Child Support Cooperation or Reason for Transfer to TP 07/20)

TANF

Code or Action	Definition
R	Refusal without good cause to cooperate with child support for one or more APs

Code or Action	Definition
X	Exempt from child support requirements, or claiming good cause for all APs
C	Cooperation. Enter this code if Codes R or X do not apply
E	new or increased earned income or earnings of a returning absent parent who is added to the certified group
S	new or increased child support collections
B	TANF denial results from a reason listed under Code E and new or increased child support collections

Item 140: Code

TANF

Code or Action	Definition
1	Employment Services/Work Registration (TANF only)
2	School attendance
3	(Reserved)
4	Management
5	Income/Expense changes anticipated
6	Living arrangement change anticipated
7	Medical review
8	Household change anticipated
9	Other
Q	Disability Hardship Exemption (TANF only)

Item 142: Hold CD: Date

TANF

Advisor Hold Codes

Code or Action	Definition
1	Unable to locate
2	Guardianship pending
3	New payee pending
4	Notice of adverse action to lower benefits that expires between cutoff and the end of the month
5	Notice of adverse action expires between cutoff and end of month (case denial or transfer to TP 07 or TP 20)

State Office Hold Codes

Code or Action	Definition
A	Hold, Form H1000-B has fatal error not cleared by cutoff
C	Form H3087 returned, moved
D	Form H3087 returned, deceased
E	Form H3087 returned, unclaimed
F	Warrant Undeliverable and returned by post office
G	Warrant undeliverable because individual is deceased
H	TANF case has SIG 5 member age 19 or over
L	State time limit expiring and SAVERR cannot rebudget TANF
J	Warrant charged back
R	SDX hold
Z	Dormant EBT account
3	RCA case has a member who entered the United States eight months ago
6	TANF case pending denial or transfer to TP 20

Advisor Release Codes

Code or Action	Definition
8	Release benefits as originally authorized
9	Release benefits as originally authorized using the new address on this Form H1000-B
0	Release future benefits. Use Form H1008 to release any returned benefits. Use Section XI to issue benefits for months on hold.

Item 149: Code

TANF

Code or Action	Definition
C	Dependent care deduction
9	A 90% earned income deduction up to $1400 per employed member or 12 or 18 months additional Medicaid coverage. This entry requires an entry on the same line in Item 151.

Item 179 - Type of Warrant Requested

TANF

Code or Action	Definition
1	Full months amount
2	Additional amount for a month; Form H1000-B use only

SNAP

Code or Action	Definition
S	Reporting ATA issuance untimely
E	Requesting issuance or timely reporting benefits issued via the ATA
N	Requesting cancellation of benefits

Item 180: Type Issuance

TANF

Reason for authorization of benefits

Code or Action	Definition
9	Action Code 090, simultaneous open and close on Form H1000-A only
B	Change in both household composition and money reflected in the budget
H	Change in household composition
M	Change in money reflected in the budget
O	Retroactive or current month's benefit when releasing a case from hold with release Code 0 or 7 in Item 142
P	Budgeting process requires different payment month benefits. Enter Code 1 in Item 179
R	(State office use only) Identifies on the history file benefits produced when release Code 8 or 9is used to release a case from hold
T	Transfer from TP 07, 20, 29, or 37 to TP 01/61 (Form H1000-B and Form H1000-C use only)

SNAP

Full Regular Ongoing Benefits or Their Replacements

Code or Action	Definition
A	Initial benefit (regular ongoing benefit)
E	Initial expedited benefit issued*
H	Priority benefits issued to meet hearing officer decision timeliness

Code or Action	Definition
L	Restoring benefits for a past month
1	Initial expedited benefits issued through ATA*
2	Priority benefits issued through SAVERR or ATA to meet timeliness
3	Initial priority benefits issued through ATA*
4	Historical Information: CCDMI mailed out of state as a result of converting EBT benefits to coupons (state office use only). No longer in use effective April 1, 2004.
5	Historical Information: Benefits replaced in EBT account when CCDMI was returned (state office use only). No longer in use effective April 1, 2004.

*See details in C-500, Item 180 instructions.

Additional Benefits for a Month

Code or Action	Definition
C	Supplemental benefits. Use when providing benefits in addition to initial benefits for the current month, or following month if submitting Form H1000-A, Form H1000-B and Form H1000-C after cutoff.
D	Restoration benefits. Use when restoring partial benefits for a past month.
F	Supplemental or restoration benefits. Use when providing additional benefits for a month in which the household has already received one issuance coded C or D.
P	Restore an erroneously expunged EBT benefit.

Destroyed Food

Code or Action	Definition
T	Replacement of destroyed food, which was purchased with SNAP benefits

Advisor enter cancellation

Code or Action	Definition
G	Use to cancel EBT benefit because the household has moved out of state

Item 186: Other Data (Range Code)

SNAP

Code or Action	Definition
P	Initial month benefit prorated

Benefit Range Code for all issuances coded C, D, F, H, P, or T in Item 180.

Range Code	Issuance Dollar Amount	Range Code	Issuance Dollar Amount
A	1 - 49	H	350 - 399
B	50 - 99	J	400 - 449
C	100 - 149	K	450 - 499
D	150 - 199	L	500 - 549
E	200 - 249	M	550 - 599
F	250 - 299	X	600 or over
G	300 - 349	-	-

Item 187: Household Composition for Benefit Requested

TANF

- **1st digit** - Number of individuals with status-in-group (SIG) code 7 and 8 (maximum of two). If none, enter 0.
- **2nd and 3rd digits** - Number of individuals with status-in-group Code 5 (maximum of nine). Always enter as two-digit number. If none, enter 00. If there are more than nine Code 5s, use Form H1008.

Note: See C-500 for additional codes and instructions to Form H1000-C. A Form H1000-C cannot be submitted without Form H1000-A or Form H1000-B.

Item 214: FIC (R/E) (Finger Image Code)

TANF and SNAP

Enter individual's finger image enrollment or exemption code.

Code or Action	Definition
Y	If all available images have been taken
Z	If one image has been taken
A	Appeal pending (TANF related)
B	Low quality image, physically unable to image or equipment failure
C	Certified out of office or unable to come to office
D	Undue burden for disabled individual
E	Undue burden for elderly individual
F	Disqualified (FS only)

D — Undue burden for disabled individual

E — Undue burden for elderly individual

F — Disqualified (FS only)

Item 215: LSIS Vendor's Unique Number (VUN)

TANF and SNAP

If the entry in Item 214 is Y or Z, enter the nine-digit VUN.

Item 216: Disqualification Type

SNAP

Enter the code(s) to indicate that an individual is being disqualified for one or more the following reasons.

Code or Action	Definition
B	ineligible alien without BCIS document
C	ineligible aliens with BCIS document
D	felony drug conviction
F	first offense failure to comply with ESP requirements (E&T, voluntary quit or reducing work hours to less than 30)
J	fugitive
N	failure to meet SSN requirement
S	second offense failure to comply with ESP requirements
T	third or subsequent offense failure to comply with ESP requirements
W	failure to comply with the 18-50 work requirement

Item 217: Remove

SNAP

Enter a code below to end a disqualification or change a time-limited benefit code.

Code or Action	Definition
1	delete the first countable month
2	delete the second countable month
3	delete the third countable month

Code or Action	Definition
4	delete the fourth countable month (first month of second three month period)
B	end the ineligible alien (undoc) disqualification
C	end the ineligible alien (doc) disqualification
F	end the first offense SNAP ESP disqualification
J	end the fugitive disqualification
L	subtract one offense from the ESP offense counter (when entering Code L, do not enter Code F, S, or T in Item 216 on the same Form H1000-A, Form H1000-B and Form H1000-C transaction)
N	end of the SSN disqualification
S	end the second offense SNAP ESP disqualification
T	end the third offense SNAP ESP disqualification
W	end the 18 - 50 work requirement disqualification

Items 218-223

SNAP

Make entries in these fields to report that HHSC has authorized a SNAP benefit for a countable month of the initial or second three-month period of time-limited benefits in a 36 month period for an individual age 18-50. Make entries of Code(s) 1-4 in Items 218 and the corresponding month(s) in Item 219.

Items 218, 220, and 222 – Countable Month Code

SNAP

Enter one of the following codes and a corresponding month in Item 219, 221, and 223:

Code or Action	Definition
1	benefit authorized for the first month of the initial three-month period
2	benefit authorized for the second month of the initial three-month period
3	benefit authorized for the third month of the initial three-month period
4	benefit authorized for the first month of the second three-month period

Additional Codes

TANF

Benefit History Codes

Code or Action	Definition
A	Mailed warrant or EBT benefit issued
C	Warrant held
D	Warrant or EBT issuance cancelled
E	Warrant charged back
P	Warrant paid by state treasure
R	Warrant returned
S	Warrant stop payment in effect
L	Warrant stop payment lifted
Y	Duplicate EBT benefit or warrant issued
Z	Duplicate warrant returned

Read benefit history codes on inquiry from right to left. The most recent code or action appears on the far left.

C-540, Code Summary

Body

Revision 08-4; Effective October 1, 2008

TANF and SNAP

This section contains a Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action, and Form H1000-C, Secondary Client Input, instructions code summary.

ITEM 02: Category

TANF

2 — TANF

5 — Refugee Cash Assistance (RCA)

SNAP

6 — Public Assistance (PA) SNAP Case

8 — Refugee, PA SNAP

9 — Non-PA SNAP Case

ITEM 03: Sequence No. (SEQ)

TANF and SNAP

Y — Yes

Item 27: Modifier (M)

TANF

P — Protective Payee

R — Representative Payee

SNAP

I — Authorized representative (AR) is a member of household (under the same roof).

O — AR is not a member of household (not under the same roof).

F — AR is an employee of a drug and alcohol treatment/group living arrangement facility.

ITEM 28: Indicator Code

TANF

M — Incapacity

TANF-UP

U — (system entered when TP 61 transfers to TP 07, 20 or 37)

SNAP

1 — Streamlined reporting (SR) household with total gross monthly income that is less than or equal to 130% of the Federal Poverty Income Limits (FPIL).

2 — SR household with total gross monthly income that is greater than 130% FPIL.

3 — Non-SR household.

ITEM 32: Client Number

TANF and SNAP

2 — Check for an existing number.

ITEM 35: Sex

TANF and SNAP

M — Male

F — Female

ITEM 36: Race

TANF and SNAP

1 — White

2 — Black

3 — Hispanic

4 — American Indian or Alaskan Native

5 — Asian or Pacific Islander (includes Indochinese)

6 — Computer entered code indicating inappropriate or omitted code. Must be corrected.

ITEM 39: Education/Service Code

TANF and SNAP

1 — First Grade

2 — Second Grade

3 — Third Grade

4 — Fourth Grade

5 — Fifth Grade

6 — Sixth Grade

7 — Seventh Grade

8 — Eighth Grade

9 — Ninth Grade

A — Tenth Grade

B — Eleventh Grade

C — High School Graduate/completed general equivalency diploma

E — Attending college or completed some college but has not graduated from a four-year college

F — Graduate of a four-year college

N — No formal education

ITEM 40: Status in Group

TANF

Primary Codes

2 — Disqualified/ineligible child or second parent

3 — Noncertified child: Identifies the only deprived child of the certified caretaker/second parent

If the child receives ...	then enter SIG Code
SSI	3
Foster Care Payments	3F
Adoption Assistance payments	3A

5 — Certified Child

7 — Second Parent

8 — Caretaker

9 — Payee

0 — Case Name Only:

Secondary Codes

G — Reached End of Time Limit

H — Eligible Refugee

I — Ineligible Child

K — Child of a Minor Child

L — Minor Parent with a Dependent Child

M — Eligible Only for Three Months Prior Medical Assistance

N — Ineligible for Retroactive Medical Assistance and Current Assistance

P — Private Health Insurance

Q — Proof of THSteps Screening

R — HHSC Employee

S — Alien with Acceptable Alien Status

T — Ineligible Alien

U — Ineligible - No Citizenship Proof

V — Living in Nursing Home

W — Disqualified Child

X — Deceased

Y — Disqualified Second Parent

Z — Migrant

SNAP

Head of Household Codes

A — Household head

G — Household head is nonmember

GK — Head of household disqualified for a reason other than an IPV

GT — Head of household is disqualified for intentional program violation (IPV)

Other Codes

B — Student

C — ABAWD not meeting 18-50 work requirement

D — ABAWD meeting 18-50 work requirement

F — Resident of drug and alcohol treatment/group living arrangement facility

H — Eligible Refugee

K — Disqualified for a reason other than IPV

M — Migrant, out of work stream

R — HHSC Employee

S — Eligible Alien (not a refugee)

T — Disqualified for Intentional Program Violation

U — Seasonal Farm Worker

W — Migrant, in work stream

ITEM 41: Employment Services/Work Registration

TANF

Codes	Explanation
A	Child (SIG 5 or 5L)
B	Caretaker or second parent, age 18 or younger attending school
C	Caring for an ill or disabled child in the household, even if the child is not a member of the certified group
E	Unable to work due to a disability expected to last more than 180 days
F	60 years of age or older
G	Caring for a child (SIG 2, 3, or 5) under age 1
H	Presence required in home due to illness or incapacity of another adult household member and the disability is expected to last more than 180 days
J	Not subject to participation – not a certified TANF individual
K	Pending during appeal of denial or disqualification
L	County Hardship Exemption
M	Mandatory registrant
N	Employment Hardship Exemptions
P	Mandatory registrant employed or self-employed 30 or more hours per week and earning at least $700 a month
Q	Severe Personal Hardship Exemption
R	Caring for child under age 1 who is not listed on Form H1000-A, Form H1000-B and Form H1000-C
T	Pregnant and unable to work
U	A single grandparent age 50 or over caring for a child under age three
V	An SSI recipient parent.
W	Identifies a individual who noncomplies with the Choices program
X	A parent who has exhausted state time limits.
Y	A parent who is disqualified due to third party resource (TPR) requirements, Social Security number requirements, intentional program violation, failure to report a child's absence, being a fugitive, having a felony drug conviction, failure to cooperate with Quality Control or noncompliance with the unmarried minor parent domicile requirement.

SNAP

Codes	Explanation
A	Child age 16 years of age or child age 16 or 17 who attends school at least half-time, or is not the head of household
D	Three to nine-months pregnant
E	Physically or mentally unfit for employment
F	60 years of age or older
G	Caring for a child under age six

Codes	Explanation
H	Presence in home required for care of an incapacitated person
J	Person in drug addiction or alcoholic treatment and rehabilitation program
N	Receiving or applying for unemployment compensation
P	Employed or self-employed 30 hours or more a week
Q	Individual resides in a Choices county and is mandatory or has volunteered for TANF employment services
R	Registered again, after previously serving the E&T noncompliance penalty period
S	Student exemption (age 18 or older/in a training program)
T	Disqualified household member or nonmember head of household
U	Primary wage earner failed to comply with SNAP employment services
2	Registered, employed less than 30 hours a week
3	Registered, not working
4	Registered, job attached (temporarily laid off)
5	Registration postponed, expedited service

ITEM 42A: Type Income

TANF and SNAP

A — Veteran's Administration (VA) benefits

C — Unemployment Insurance benefits

P — Pension benefits (other than RSDI, SSI, VA, or RR)

M — Combination of unemployment benefits with benefits from a pension, VA, or both

W — Combined income from VA and a pension

ITEM 49: Disqualification Code (Intentional Program Violation)

SNAP

1st digit	**T** – Administrative disqualification for offense which occurred prior to September 22, 1996 **S** – Administrative disqualification for offense which occurred on or after September 22, 1996, or disqualification for conviction due to trafficking **C** – Court-ordered disqualification **M** – Disqualification due to receipt of multiple benefits in one month.
2nd digit	**1** – 1st disqualification **2** – 2nd disqualification **3** – 3rd disqualification **4** – permanent disqualification for trafficking in SNAP benefits or program access devices of $500 or more.
3rd – 6th digits	**MMYY** – last month of disqualification **PERM** – disqualification permanent

ITEM 50: Error Messages

TANF and SNAP

The following format is used for all error messages: AAABBCCC

AAA — Form item number 001-191; client items 32-50 will be shown A32-K32, through K50. When a client item is shown without line indicator, 032-050, then the comparison of all entries within that item caused the error.

BB — One of the following two-digit qualifiers:

EC – ERROR CODE NUMBER"CCC"
EQ – EQUAL
GE – GREATER THAN OR EQUAL
GT– GREATER THAN
LE – LESS THAN OR EQUAL
LT – LESS THAN
NA – NOT ALLOWABLE WITH THE ENTRY OR LACK OF ENTRY IN "CCC"
NE– NOT EQUAL

CCC — Form item number 001-191; or error code number 300-999; or one of the following "KEY" words:

ALP – ALPHABETIC
BLK – BLANK
CUR – CURRENT PROCESS MONTH
DAT – VALID DATE
FIL – VALUE ALREADY ON FILE
N-3 – today minus 3 months
N-6 – today minus 6months
N12 – today minus 12 months
N24 – today minus 24 months
N45 – today minus 45 days
NAM – NAME FORMAT
NOW – PROCESS DATE OF FORM
NUM – NUMERIC
NXT – NEXT PROCESS MONTH
VAL – VALID

Error Codes

300 — Either the first digit of application number is not A or the last eight digits are not numeric

301 — By changing the A of the application number to zero, it was found that a case already on file has been assigned that number.

304 — Application already disposed

305 — BJN was incorrect

307 — The case or individual indicated is already active in the same program area for the benefit period requested.

308 — The client number entered cannot be reassigned due to a mismatch of client information.

309 — Multiple entries for this item contained the same value.

320 — A SNAP denial cannot precede a benefit issuance month.

321 — The ATA issuance exceeded the maximum allotment for household size.

400 — The individual's SSI coverage was changed to SUSPENSE

402 — Hierarchy of individual information prevented the use of the client entries on the transaction.

403 — The entry made in Adjusted Gross Income is zero. Determine if the correct income was entered.

404 — Valid entries for case number reassignment are required.

500 — The rejection of this attempted denial caused the case to be placed on hold.

ITEM 78: Type of Review

SNAP

C — Complete review

I — Incomplete review

N — Non-review activity (case maintenance)

ITEM 79: Application Codes

SNAP

First Digit – Application Type	**1** – Eligibility Determination **2** – Redetermination **3** — Application reopened after denial
Second digit	Enter X
Third digit – Number of Months	**0** – All initial applications, reapplications within 30 days from previous application, or later applications within 30 days after the end of the previous certification period. **1-8** – Enter the number of months, as appropriate, since the last application or certification period. **9** – Nine months or longer since the last application or certification period.

ITEM 84: AID

SNAP

1 — NPA Only

2 — NPA Mixed

3 — TANF-PA

5 — Refugee, PA

ITEM 85: Test (Income Test/Shelter Deduction Identifier)

SNAP

B — Gross and net income tests with capped shelter deduction.

C — Categorically eligible household with capped shelter deduction.

E — Gross and net income test and uncapped shelter deduction. Use this code only if the member who is entitled to uncapped shelter costs is disqualified for intentional program violation.

M — Net test only, uncapped shelter deduction.

T — Categorically eligible household with uncapped shelter deduction. **Note:** This code is also used in situations where a household member, disqualified for any reason, is the only elderly or disabled member.

ITEM 87: NON (Non H/H Members)

SNAP

A — Attendant

B — Boarders

C — Ineligible alien

D — Ineligible student

E — Any combination of two or more of A, B, C, or D

ITEM 89: SSI

SNAP

X — Every household member receives SSI

ITEM 90: Util (Utility Expense Code)

SNAP

Code	Description
1	Household claiming the Standard Utility Allowance.
2	Household claiming telephone standard only, or telephone standard plus actual utilities.
3	Household claiming actual utility costs only (even if some members are disqualified).
4	Household without utility costs.
5	Two households live together and share the standard utility allowance.
6	Households claiming the standard utility allowance with member(s) disqualified for not meeting the citizenship, 18-50 work, and/or SSN requirements.
7	All other proration situations. A combination of households described in Codes 5, 6, B, and C, a prorated telephone standard, and all other situations in which the utility allowance is prorated (such as a proration involving three or more households, or more than one disqualified member).
8	Household claiming the homeless shelter standard
9	Household claiming the homeless shelter standard with one member who is disqualified for not meeting the citizenship, 18-50 work and/or SSN requirements
A	Households claiming the basic utility allowance.
B	Two households live together and share the basic utility allowance.
C	Households claiming the basic utility allowance with member(s) disqualified for not meeting the citizenship, 18-50 work, and/or SSN requirement.

Codes 1, 2, 3, 4, 5, 7, A, and B are allowed for household containing member(s) disqualified for an intentional program violation, felony drug conviction, E&T non-compliance, and/or being a fugitive.

Codes 3, 4, 6, 7, 9, and C are allowed for households containing member(s) disqualified for not meeting the citizenship requirement, 18-50 work requirement, or SSN requirement. Also, these codes are allowed for household containing member(s) disqualified for an intentional program violation, felony drug conviction, E&T non-compliance, and/or being a fugitive **and** member(s) disqualified for citizenship, 18-50 work requirement, and/or SSN requirements. **Note:** Utility, homeless, and telephone standards, if used, are prorated for these kinds of disqualifications.

ITEM 91: Action Code

SNAP

See C-221, Denial Codes.

ITEM 95: Code/Hold Date

SNAP

Hold Codes

2 — Hold benefits

A — Form H1000-B has fatal error not cleared by cutoff

Z — Dormant EBT account (state office use)

Release Codes

0 — Do not hold future benefits.

ITEM 101: Prepared Meals Services Code

SNAP

C — SSI/elderly member authorized to purchase from communal dining facilities, meal delivery service, or contracted restaurant

E — Homeless and either elderly or SSI recipient; authorized to purchase from every service (communal dining, meal delivery services, or homeless meal providers/contracted restaurants)

H — Authorized to purchase from homeless meal providers/contracted restaurants

M — Household/disabled member authorized to purchase from meal delivery services

ITEM 104: Special Review Code

SNAP

Enter the appropriate code to show the type of special review needed

0 — State office assigned

1 — Employment Services/Work Registration

2 — School Attendance

3 — Reserved

4 — Management

5 — Income/Expense changes anticipated

6 — Living arrangement change anticipated

7 — Medical review

8 — Household change anticipated

9 — Other

ITEM 127 Type Program

TANF

01 — Cash and medical assistance

04 — Medical Assistance Only – Deceased

07 — 12 or 18 months medical assistance only

11 — Three months prior medical assistance only not currently eligible

20 — Medical assistance only – Child Support

37 — 12 or 18 months medical assistance only

61 — TANF-UP cash and medical assistance

71 — OTTANF – One parent household

72 — OTTANF – Two parent household

ITEM 131: Type Review

TANF

C — Complete review

I — Incomplete review

N — Non-review activity (case maintenance)

ITEM 132: Action Code

TANF

See C-200 for Item 132 Codes.

ITEM 138: (Child Support Cooperation/Reason for Transfer to TP 07/20)

TANF

R — Refusal without good cause to cooperate with child support for one or more APs

X — Exempt from child support requirements, or claiming good cause for all APs

C — Cooperation. Enter this code if Codes R or X do not apply

E — new or increased earned income or earnings of a returning absent parent who is added to the certified group

S — new or increased child support collections

B — TANF denial results from a reason listed under Code E and new or increased child support collections

ITEM 140: CODE

TANF

1 — Employment Services/Work Registration (TANF only)

2 — School attendance

3 — (Reserved)

4 — Management

5 — Income/Expense changes anticipated

6 — Living arrangement change anticipated

7 — Medical review

8 — Household change anticipated

9 — Other

Q — Disability Hardship Exemption (TANF only)

ITEM 142: HOLD CD: DATE

TANF

Advisor Hold Codes

1 — Unable to locate

2 — Guardianship pending

3 — New payee pending

4 — Notice of adverse action to lower benefits that expires between cutoff and the end of the month

5 — Notice of adverse action expires between cutoff and end of month (case denial or transfer to TP 07 or TP 20)

State Office Hold Codes

A — Hold, Form H1000-B has fatal error not cleared by cutoff

C — Form H3087 returned, moved

D — Form H3087 returned, deceased

E — Form H3087 returned, unclaimed

F — Warrant Undeliverable and returned by post office

G — Warrant undeliverable because individual is deceased

H — TANF case has SIG 5 member age 19 or over

L — State time limit expiring and SAVERR cannot rebudget TANF

J — Warrant charged back

R — SDX hold

Z — Dormant EBT account

3 — RCA case has a member who entered the United States eight months ago

6 — TANF case pending denial or transfer to TP 20

Advisor Release Codes

8 — Release benefits as originally authorized

9 — Release benefits as originally authorized using the new address on this Form H1000-B

0 — Release future benefits. Use Form H1008 to release any returned benefits. Use Section XI to issue benefits for months on hold.

ITEM 149: Code

TANF

C — Dependent care deduction

9 — A 90% earned income deduction up to $1400 per employed member or 12 or 18 months additional Medicaid coverage. This entry requires an entry on the same line in Item 151.

Item 179 - Type of Warrant Requested

TANF

1 — Full months amount

2 — Additional amount for a month; Form H1000-B use only

SNAP

S — Reporting ATA issuance untimely

E — Requesting issuance or timely reporting benefits issued via the ATA

N — Requesting cancellation of benefits

ITEM 180: Type Issuance

TANF

Reason for authorization of benefits

9 — Action Code 090, simultaneous open and close on Form H1000-A only

B — Change in both household composition and money reflected in the budget

H — Change in household composition

M — Change in money reflected in the budget

O — Retroactive and/or current month's benefit when releasing a case from hold with release Code 0 or 7 in Item 142

P — Budgeting process requires different payment month benefits. Enter Code 1 in Item 179

R — (State office use only) Identifies on the history file benefits produced when release Code 8 or 9is used to release a case from hold

T — Transfer from TP 07, 20, 29, or 37 to TP 01/ 61 (Form H1000-B and Form H1000-C use only)

SNAP

Full Regular Ongoing Benefits or Their Replacements

A — Initial benefit (regular ongoing benefit)

E — Initial expedited benefit issued*

H — Priority benefits issued to meet hearing officer decision timeliness

L — Restoring benefits for a past month

1 — Initial expedited benefits issued through ATA*

2 — Priority benefits issued through SAVERR or ATA to meet timeliness

3 — Initial priority benefits issued through ATA*

4 — Historical Information: CCDMI mailed out of state as a result of converting EBT benefits to coupons (state office use only). No longer in use effective April 1, 2004.

5 — Historical Information: Benefits replaced in EBT account when CCDMI was returned (state office use only). No longer in use effective April 1, 2004.

*See details in C-500, Item 180 instructions.

Additional Benefits for a Month

C — Supplemental benefits. Use when providing benefits in addition to initial benefits for the current month, or following month if submitting Form H1000-A,Form H1000-B and Form H1000-C after cutoff.

D — Restoration benefits. Use when restoring partial benefits for a past month.

F — Supplemental or restoration benefits. Use when providing additional benefits for a month in which the household has already received one issuance coded C and/or D.

P — Restore an erroneously expunged EBT benefit.

Destroyed Food

T — Replacement of destroyed food, which was purchased with SNAP benefits

Advisor enter cancellation

G — Use to cancel EBT benefit because the household has moved out of state

ITEM 186: OTHER DATA (Range Code)

SNAP

P — Initial month benefit prorated

Benefit Range Code for all issuances coded C, D, F, H, P, or T in Item 180

Range Code	Issuance Dollar Amount	Range Code	Issuance Dollar Amount
A	1 - 49	H	350 - 399
B	50 - 99	J	400 - 449
C	100 - 149	K	450 - 499
D	150 - 199	L	500 - 549
E	200 - 249	M	550 - 599
F	250 - 299	X	600 or over
G	300 - 349	-	

ITEM 187: Household Composition for Benefit Requested

TANF

1st digit	Number of individuals with status-in-group (SIG) code 7 and 8 (maximum of two). If none, enter 0.

2nd and 3rd digits	Number of individuals with status-in-group Code 5 (maximum of nine). Always enter as two-digit number. If none, enter 00. If there are more than nine Code 5s, use Form H1008.

Note: See C-500 for additional codes and instructions to Form H1000-C. A Form H1000-C cannot be submitted without Form H1000-A or Form H1000-B.

ITEM 214: FIC (R/E) (Finger Image Code)

TANF and SNAP

Enter individual's finger image enrollment or exemption code

Y — If all available images have been taken

Z — If one image has been taken

A — Appeal pending (TANF related)

B — Low quality image/physically unable to image/equipment failure

C — Certified out of office or unable to come to office

D — Undue burden for disabled individual

E — Undue burden for elderly individual

F — Disqualified (FS only)

ITEM 215: LSIS Vendor's Unique Number (VUN)

TANF and SNAP

If the entry in Item 214 is Y or Z, enter the nine-digit VUN.

ITEM 216: Disqualification Type

SNAP

Enter the code(s) to indicate that an individual is being disqualified for one or more the following reasons.

B — ineligible alien without BCIS document

C — ineligible aliens with BCIS document

D — felony drug conviction

F — first offense failure to comply with ESP requirements (E&T /voluntary quit/reducing work hours to less than 30)

J — fugitive

N — failure to meet SSN requirement

S — second offense failure to comply with ESP requirements

T — third or subsequent offense failure to comply with ESP requirements

W — failure to comply with the 18-50 work requirement

ITEM 217: Remove

SNAP

Enter a code below to end a disqualification or change a time-limited benefit code.

1 — delete the first countable month

2 — delete the second countable month

3 — delete the third countable month

4 — delete the fourth countable month (first month of second three month period)

B — end the ineligible alien (undoc) disqualification

C — end the ineligible alien (doc) disqualification

F — end the first offense SNAP ESP disqualification

J — end the fugitive disqualification

L — subtract one offense from the ESP offense counter (when entering Code L, do not enter Code F, S, or T in Item 216 on the same Form H1000-A, Form H1000-B and Form H1000-C transaction)

N — end of the SSN disqualification

S — end the second offense SNAP ESP disqualification

T — end the third offense SNAP ESP disqualification

W — end the 18 - 50 work requirement disqualification

ITEMS 218-223

SNAP

Make entries in these fields to report that HHSC has authorized a SNAP benefit for a countable month of the initial or second three-month period of time-limited benefits in a 36 month period for an individual age 18-50. Make entries of Code(s) 1-4 in Items 218 and the corresponding month(s) in Item 219.

ITEMS 218, 220, and 222 - Countable Month Code

SNAP

Enter one of the following codes and a corresponding month in Item 219, 221, and 223:

1 — benefit authorized for the first month of the initial three-month period

2 — benefit authorized for the second month of the initial three-month period

3 — benefit authorized for the third month of the initial three-month period

4 — benefit authorized for the first month of the second three-month period

Additional Codes

TANF

Benefit History Codes

A — Mailed warrant/EBT benefit issued

C — Warrant held

D — Warrant or EBT issuance cancelled

E — Warrant charged back

P — Warrant paid by state treasure

R — Warrant returned

S — Warrant stop payment in effect

L — Warrant stop payment lifted

Y — Duplicate EBT benefit or warrant issued

Z — Duplicate warrant returned

Read benefit history codes on inquiry from right to left. The most recent code/action appears on the far left.

C-600, Form H1000-A and Form H1000-B Entries (Retired as of July 1, 2013)

C-610, General Information

Body

Revision 02-3; Effective April 1, 2002

All Programs

This section contains Form H1000-A, Notice of Application, and Form H1000-B, Record of Case Action, entries for certifications, actions taken during certification periods, and denials. For transfer entries, refer to C-700, Transfer Guidelines.

C-620, Certification Entries

Body

C—621 Minimum Entries for Certification

Revision 02-3; Effective April 1, 2002

C—621.1 TANF Minimum Entries

Revision 02-3; Effective April 1, 2002

TANF

Section I

Item	Detail
02	Category
07	Mail Code
08	Date Filed
09	Case Name
13	Mailing Address
15	City
16	State
17	ZIP Code
25	County

Section II

Item	Detail
32	Client Number
33	Client Name
34	Birth Date
35	Sex
37	Social Security Number (if known)
38	Social Security Claim Number (if enrolled in Medicare or receiving benefits)

Section III

Item	Detail
40	Status in Group
41	ESP Code (unless Category 5)
42-44	Individual Income, if applicable
46	Medical Effective Date

Section IV

Item	Detail
55	Total Railroad Retirement (if appropriate)
56	Total Other (Income) (if appropriate)
58	Dependent Care Deductions (if appropriate)
59	Adjusted Gross Income

Note: Total income minus deductions must equal adjusted gross income.

Section V

Item	Detail
66	Total Needs

Section VIII

Item	Detail
127	Type Program
129	Grant Effective Date
132	Action Code
133	Three Months Prior Indicator (only if eligible for three months prior medical assistance)
134	Three Months Prior Application Date (if entry made in Item 133)
138	Child Support Cooperation
149, 151 and 152	For cases with earned income, enter dependent care and 90% earned income deduction information if these deductions are used in determining the adjusted gross

Section XIV

Item	Detail
188	Signature
189	Date Signed
190	Employee Number

C—621.2 SNAP Minimum Entries

Revision 02-3; Effective April 1, 2002

SNAP

Section I

Item	Detail
02	Category
04	Page number and the number of pages if there are more than 11 individuals
06	Budgeted Job Number
07	Mail Code
08	Date Filed
09	Case Name
13	Mailing Address – first line
15	City
16	State

Item	Detail
17	ZIP Code
25	County

Section II

Item	Detail
32	Client Number
33	Client Name
34	Birth Date
35	Sex (if known)
36	Race (if known)
37	Social Security Number
38	Social Security Claim Number (if visually verified)
39	Education Level (if Item 41 is 1, 2, 3, or 4)

Section III

Item	Detail
40	Status in Group
41	Work Registration
42-45	Individual Income, if applicable
48	Medical Cost of eligible members as appropriate
49	Disqualification Code and Date, if applicable

Section IV

Item	Detail
55	Total Railroad Retirement (if appropriate)
56	Total Other (Income) (if appropriate)
58	Dependent Care Deduction (if any)
59	Adjusted Gross Income

Section V

Item	Detail
60	Shelter
63	Net Income

Section VI

Item	Detail
78	Type Review
79	Application Codes
80	Certification Date
81	Months Certified
82	Last Benefit Month
83	Household Number
84	Aid Type
85	Test (Gross/net income eligibility test identifier codes)
89	SSI Code (if applicable)
90	Utility Code
91	Action Code (if case is opened and closed on same document)
92	Action date (if entry made in Item 91)
96	Late Determination/Rescheduled Appointment Date, if applicable
103 and 104	(if appropriate)

Section VII

Item	Detail
112 and 113	Associated TANF case numbers, if appropriate
118-122	(if appropriate)

Section VIII

Item	Detail
152	Child Support Disregard, if applicable

Section XI

Item	Detail
179-187	As appropriate to request or report benefits

Section XIV

Item	Detail
188	Signature
189	Date Signed
190	Employee Number

C—621.3 Minimum Entries for Medical Programs

Revision 02-3; Effective April 1, 2002

Medical Programs except TP 45

NOA Entries

Section I

Item	Detail
01	Case Number
02	Category
03	Prior Recipient
06	Budgeted Job Number
07	Mail Code
09	Case Name
12	Employee Number
13	Mailing Address
15	City
16	State
17	ZIP Code
25	County
31	Medical Programs Application Number

Section II

Item	Detail
33-38	Client Names and Biographical Data

Certification Entries

Section I

Item	Detail
02	Category
07	Mail Code
08	Date Filed
09	Case Name
13	Mailing Address
15	City
16	State
17	ZIP Code
25	County
29	Notice Date
30	Medical Delay (if appropriate)

Section II

Item	Detail
32	Client Number
33	Client Name
34	Birth Date
35	Sex
37	Social Security Account Number (if known)
38	Social Security Claim Number (if enrolled in Medicare or receiving benefits)

Section III

Item	Detail
40	Status in Group
42-44	Individual Income, if applicable
46	Medical Effective Date

Section IV

Item	Detail
55, 56 and 58	Case Income, if applicable
59	Adjusted Gross Income

Note: Total income minus deductions must equal adjusted gross income.

Section V

Item	Detail
66	Total Needs

Section VIII

Item	Detail
125	Number of Adults
126	Number of Children

Section VIII

Item	Detail
127	Type Program
132	Action Code
133	Three Months Prior Indicator only if eligible for three months prior medical assistance
134	Three Months Prior Application Date (if entry is made in Item 133)
136	Medicaid Termination Date

Section XIV

Item	Detail
188	Signature
189	Date Signed
190	Employee Number

C—621.3.1 TP 45 Minimum Entries

Revision 02-3; Effective April 1, 2002

TP 45

Section I

Item	Detail
02	Category
07	Mail Code
08	Date Filed
09	Case Name
13	Mailing Address
15	City
16	State
17	ZIP Code
25	County
29	Notice Date

Section II

Item	Detail
32	Client Number
33	Client Name
34	Birth Date
35	Sex
37	Social Security Account Number (if known)

Section III

Item	Detail
40	Status in Group
46	Medical Effective Date

Section VIII

Item	Detail
127	Type Program
132	Action Code

Section XIV

Item	Detail
188	Signature
189	Date Signed
190	Employee Number

C—622 Entries for Three Months Prior

Revision 02-3; Effective April 1, 2002

C—622.1 Three Months Prior Medicaid – Currently Eligible – No Gap in Coverage

Revision 02-3; Effective April 1, 2002

TANF

Complete Form H1000-A, Notice of Application, using TANF entry requirements.

Item 46 – Enter prior medical effective dates for applicants eligible for three months prior medical coverage.

Item 133 – Enter the number of months of prior eligibility.

Item 134 – Enter three months of prior application date.

Note: For three months prior with a gap in coverage, see C-623.2.

C—622.2 Three Months Prior Entries for a Medically Needy Case

Revision 02-3; Effective April 1, 2002

TP 55 and 30

Make minimum certification entries for a case with or without spend down. For a TP 30 case, do not make entries in Items 179-187 if Item 137 has an entry of 40, 43, 44, or 48. Refer to Form H1000-A and Form H1000-B instructions for Items 133 and 137.

Make the following entries in Section XI when there is no gap in eligibility during the prior period:

Item 179 – Enter N if the prior month has spend down or E if the prior month does not have spend down. This code corresponds with the month entered in Item 183.

Item 183 – Enter the month to correspond with the code in Item 179.

Item 184 – Enter the net income to correspond with the month in Item 183. Round down to the whole dollar amount.

Item 185 – Enter the spend down amount to correspond with the month entered in Item 183. Enter 0 if there is no spend down.

Item 187 – Enter the household size to correspond with the month entered in Item 183. Enter the number of adults in the budget group in the first digit and the number of children in the budget group in the second digit.

If there is a gap in eligibility during the three-month prior period, process a separate Form H1000-A for the eligible months.

C—623 Entries for Open and Close Certifications

Revision 02-3; Effective April 1, 2002

C—623.1 TP 04, Medical Assistance Only – Deceased

Revision 02-3; Effective April 1, 2002

TANF

Make TANF minimum entries except for Items 41 and 129

Item 40 – Enter X with status in group code for deceased individual.

Item 46 – Enter the medical effective date for each eligible person.

tem 47 – Enter the appropriate dates.

Item 132 – Enter action code 090.

Item 133 – Enter three months prior indicator, if eligible.

C—623.2 TP 11, Three Months Prior Medical Assistance – Not Currently Eligible; Gap in Coverage; or Reopened Applications

Revision 02-3; Effective April 1, 2002

TANF

Make all TANF minimum entries except Items 41 and 129.

For reopened applications,

Item 08 – Enter the date the applicant requests the application be reopened.

Item 134 – Enter the month and year the original application was filed.

Item 140 – Enter M with primary Codes 5, 6, 7, or 8 for applicants eligible for retroactive coverage. Enter N with primary Codes 5, 7, or 8 for applicants who are not eligible for retroactive coverage but are included to show need.

Item 47 – Enter last day of medical coverage for all applicants with Code M in Item 40.

Item 132 – Enter Code 090.

Notes:

- Enter MX with primary codes for an applicant who dies during the three month prior period or if the person died before the application was made on his behalf.
- For Three Months Prior Currently Active – In addition to the above entries, enter the existing case number in Item 01 and the existing client number in Item 32.

C—623.3 Simultaneous Open and Close for TANF

Revision 02-3; Effective April 1, 2002

TANF

Use this procedure to process applications for

- denied households eligible for restored benefits (See B-800, Restored Benefits),
- applicants eligible for TANF for the current month but ineligible for future months,
- applicants eligible for OTTANF, or
- applicants eligible for TANF Medicaid for the application month but ineligible for the months following the application month. **Note:** Form H1000-A, Notice of Application, can be processed only if the month after the application month is entered in Item 129.

Make all minimum entries for the appropriate type program.

Note: Do not reassign an old case number.

Item 40 – Enter secondary status in group Code N for OTTANF applicants.

Item 47 – Enter last month of eligibility for each certified person. If an applicant is deceased, enter date of death.

Item 127 – enter Type Program 71 or 72 for OTTANF cases.

Item 132 – Enter Code 090.

Items 179, 180, 183, 184, 185 and 187 (Section XI) – Enter information to authorize benefits for Type Program 01 and 61 certifications. **Exceptions:** Do not make entries in Section XI for OTTANF cases. When the form processes, benefits are automatically issued.

C—623.4 Simultaneous Open and Close for Medical Programs

Revision 02-3; Effective April 1, 2002

Medical Programs

Use this procedure to process applications for

- TP 55 and 30 with spend down in the application month;
- TP 30 when the applicant is a caretaker or a second parent with an emergency condition; or
- three months prior only including
  - TPs 30 and 55 with or without spend down, and
  - applications for TPs 30, 40, 43, 47, 48, and 55 reopened within two years after the original application was filed.

Make minimum certification entries for a case (with or without spend down) including the file date of the application. **Note:** Do not reassign an old case number.

Item 40 – Enter the appropriate SIG codes. For three months prior, only include in the certified group members who have Title XIX-reimbursable bills for the prior period. For TP 30, include only one member in the certified group.

Item 46 – Enter the Medical Effective Date (MED) or earliest possible MED. For TP 30 cases, enter the start date of the emergency condition taken from Form H3038, Emergency Medical Services Certification.

Item 47 – Enter the last day of medical coverage. For TP 30 cases enter the earliest of either

- the end date of the emergency condition, or
- the last day of the application month.

Note: For TP 55 cases with spend down, computer edits will not allow a date later than the last day of the application month.

Item 66 – Enter the correct needs allowance for the month(s) entered in Items 46 and 47.

Item 127 – Enter the correct type program (30, 40, 43, 44, 47, 48, or 55).

Item 132 – Enter code 090.

Item 133 – For three months prior only, enter the total number of unduplicated calendar months of three months prior.

Item 137 – For TP 30 cases, enter the appropriate TP. Refer to Form H1000-A and Form H1000-B instructions for this entry.

Section XI – For three months prior only, make appropriate entries for each of the prior months. For TP 30 cases, do not make these entries if Item 137 has an entry of 40, 43, 44, or 48.

For reopened three months prior applications,

Item 08 – Enter the date the applicant requests the application be reopened.

Item 134 – Enter the month and year the original application was filed.

C—624 Entries for Reinstatements

Revision 02-6; Effective July 1, 2002

C—624.1 TANF

Revision 10-1; Effective January 1, 2010

Make all Form H1000-A minimum entries.

Item 01 – Enter the previous case number.

Item 08 – Enter first day of the month of reinstatement.

Item 46 – Enter each individual's medical effective date.

Item 131 – Enter type review Code C.

Item 132 – Enter Code 054 or 055.

Item 164 – Enter the three-digit code for the individual's county of residence. See C-350.

Note: SAVERR edits prevent household additions when Code 054 is used in Item 132. Use Form H1000-B turnaround to make this change.

C—624.2 SNAP

Revision 10-1; Effective January 1, 2010

SNAP

Item 08 – Enter the original file date.

Item 79 – Enter 3X0.

Item 80-82 – Reenter the information from the certification period when the case was denied.

Section XI – Make entries as appropriate to order benefits.

C—624.3 TP 07/20 (Four, 12, or 18 Months Medicaid) for a Case Previously Denied in Error

Revision 10-1; Effective January 1, 2010

TANF

Make all TANF minimum entries except Items 41 and 129.

Item 01 – Enter case number of the case denied in error.

Item 32 – Enter each individual's previous client number.

Item 46 – Enter each individual's medical effective date as the day after the date the erroneous denial became effective.

Item 132 – Enter

- Code 090 if the Medicaid end date is before the current process month, or
- Code 055 if the Medicaid end date is during or after the current process month.

Item 136 – Enter the Medicaid end date.

Item 138 – Enter the reason for transfer to TP 07 or TP 20.

Item 164 – Enter the three-digit code for the individual's county of residence. See C-350.

C—624.4 TP 37 (12 or 18 Months Medicaid) for a Case Previously Denied in Error

Revision 10-1; Effective January 1, 2010

TANF

Make all TANF minimum entries except Items 41 and 129.

Item 01 – Enter case number of the case denied in error.

Item 32 – Enter each individual's previous client number.

Item 46 – Enter each individual's medical effective date as the day after the date the erroneous denial became effective.

Item 132 – Enter

- Code 090 if the Medicaid end date is before the current process month, or
- Code 050 if the Medicaid end date is during or after the current process month, or
- Code 054 to reinstate a denied household that meets the requirements in A-800.

Item 149 – Enter Code 9 for the 90% Earned Income Deduction (EID).

Item 151 – Enter the original date of the 90% EID. Do not enter a dollar amount in Item 152.

Item 164 – Enter the three-digit code for the individual's county of residence. See C-350.

C—624.5 Reinstatement for Post Medicaid (TP 20), Transitional Medicaid (TP 07 or 37), or TP 29

Revision 10-1; Effective January 1, 2010

TANF

Make all TANF minimum entries.

Item 01 – Enter the previous case number.

Item 08 – Enter the first day of the month of reinstatement.

Item 46 – Enter each individual's medical effective date.

Item 131 – Enter Type Review Code C.

Item 132 – Enter Code 054 or Code 090.

Item 136 – TP 07, TP 20, or TP 29: Enter

- the original end date as shown on SAVERR, or
- an earlier end date, when applicable, when using Code 090.

Item 138 – Enter

- S for TP 20, or
- E or B for TP 07.

Item 151 – Enter the original date of the 90% EID. Do not enter a dollar amount in Item 152.

Item 164 – Enter the three-digit code for the individual's county of residence. See C-350.

Note: SAVERR edits prevent the actions listed below when Code 054 is used in Item 132. Therefore, use Form H1000-B turnaround to

- add a person.
- correct the end date of the original TP 07, TP 29, or TP 37 period. Change the end date only if it was incorrect when the case originally transferred to transitional Medicaid.

C—625 Miscellaneous Certification Entries

Revision 02-3; Effective April 1, 2002

C—625.1 Certifying Benefits for the Month After Certification

Revision 02-3; Effective April 1, 2002

TANF

Make all minimum TANF entries.

Item 46 – Enter first calendar day of the month after the application month.

Item 129 – Enter first calendar day of the month after the application month.

Note: Do not make future grant or medical effective dates for TANF more than one month past the future cutoff month.

C—625.2 Certifying a TP 29 Case

Revision 02-3; Effective April 1, 2002

TANF

Certify only one individual on each TP 29 case.

Item 40

- For the individual being certified on TP 29 enter
  - SIG 8G if the individual was SIG 8 on the TANF case, or
  - SIG 7G if the individual was SIG 7 on the TANF case.
- For other household members listed on the case enter
  - SIG 0 or 2Y for an adult, or
  - SIG 2, 2I, 2IT, 2IU, 2W, or 3 for a child.

Note: The case must be include a SIG 2, 2W, or 3 for the caretaker or second parent to be certified.

Item 127 – Enter Type Program 29.

Item 132 – Enter opening Code 057 on Form H1000-A, Notice of Application, or code 121 on Form H1000-B, Record of Case Action.

Item 136 – Enter the Medicaid end date.

C—625.3 Independent Child as the Case Name When a Representative from a Child Care Facility Applies for the Child

Revision 02-3; Effective April 1, 2002

Medical Programs

Make all minimum entries for the appropriate type program.

Item 13 – Enter the child's residence or, upon request, the address of the child care facility located near the child.

Item 25 – Enter the BJN's county code.

Item 26 – Enter the name of the child care representative as representative payee.

Item 271 – Enter Code R.

Item 40 – Enter SIG Code 8 to designate the child as case name.

Item 164 – Enter the child's residence county code.

C-630, Entries for Actions Taken During the Certification Period

Body

C—631 Entries for Case Name Changes

Revision 02-3; Effective April 1, 2002

C—631.1 Case Name Changes with Same Household Members

Revision 02-3; Effective April 1, 2002

SNAP

Item 10 – Enter new case name.

Item 40 – Enter # to remove former head of household status.

Item 40 – Enter A for new head of household.

Item 78 – Enter type review.

C—631.2 Case Name Changes When Head of Household Leaves

Revision 02-3; Effective April 1, 2002

SNAP

Item 10 – Enter new case name.

Item 33 – Enter # to remove former head of household.

Item 40 – Enter A for new head of household.

Item 78 – Enter type review.

Item 83 – Enter new household number, if applicable.

C—632 Entries for Households Becoming Eligible for SSI

Revision 02-3; Effective April 1, 2002

C—632.1 TANF Caretaker Becomes Eligible for SSI

Revision 08-4; Effective October 1, 2008

TANF

Item 40 – Enter Code 9.

Item 41 – Enter Code V.

Item 66 – Enter new needs amount.

Item 131 – Enter type review code.

Item 132 – Enter Code 105.

Remove any income entries for the caretaker.

C—632.2 TANF Child Becomes Eligible for SSI

Revision 02-3; Effective April 1, 2002

TANF

Item 40 – Enter Code 3.

Item 41 – Enter Code J.

Item 66 – Enter updated budget entries.

Item 131 – Enter type review.

Item 132 – Enter action code.

Note: SAVERR will not allow a SIG 5 child on the same case a SIG 3 child.

C—633.1 Extending the Certification Period of an Active SNAP Case

Revision 02-3; Effective April 1, 2002

SNAP

Item 78 – Enter Code I.

Item 81 – Enter the new number of months certified.

Item 82 – Enter the new last benefit month.

C—633.2 Shortening the Certification Period of an Active SNAP Case

Revision 02-3; Effective April 1, 2002

SNAP

Item 78 – Enter type review Code I.

Item 81 – Enter the new number corresponding to the original certification date in Item 80 and the new last benefit month in Item 82.
Example: If the certification date was 06/01/01, and the new last benefit month is 9/01, enter 04 in this item.

Item 82 – Enter the new last benefit month.

C—634 Miscellaneous Action Entries

Revision 02-3; Effective April 1, 2002

C—634.1 Death of an Active Client

Revision 02-3; Effective April 1, 2002

TANF

Item 40 – Reenter the original status in group codes for the deceased individual plus code X.

Item 47 – Enter the individual's date of death.

Item 131 – Enter the type review code.

Item 132 – If the case is also being denied because of death, enter Code 058 or 059.

C—634.2 Canceling a Previous SNAP Issuance

Revision 02-3; Effective April 1, 2002

SNAP

Item 179 – Enter Code N.

Item 180 – Enter cancellation Code G.

Item 181 – Enter number of the issuance being cancelled.

Item 182 – Enter the issuance date of the benefit being cancelled.

Item 183 – Enter the benefit month of the issuance being cancelled.

Item 185 – Enter the benefit value of the issuance being cancelled.

Item 186 – Enter the recoupment amount (if appropriate).

C—634.3 Households with Disqualified Members

Revision 02-3; Effective April 1, 2002

C—634.3.1 Households with Members Disqualified for Citizenship, or 18-50 Work Requirement, or Noncompliance with SSN Requirements

Revision 02-3; Effective April 1, 2002

SNAP

Make the following entries for the disqualified person:

Item 40 – Enter status in group Code K.

Item 41 – Enter Code T.

Items 42B-45 – Enter prorated income of disqualified person.

Item 60 – Enter appropriate shelter expenses.

Item 83 – Enter number of household members not disqualified.

Item 87 – Enter Code C if household has member disqualified as ineligible alien.

Item 88 – Enter number of household members disqualified as ineligible aliens.

Item 90 – Enter code for prorated shelter expense, if applicable.

Also make corresponding entries on Form H1000-C, Secondary Client Input, in Item 216 to identify the reason for disqualification.

C—634.3.2 Households with Members Disqualified for SNAP Employment Services Noncompliances, Felony Drug Convictions, Refusing to Cooperate with the Quality Control Process, or Being a Fugitive

Revision 08-3; Effective July 1, 2008

SNAP

Make the following entries for the disqualified person:

Item 40 – Enter status in group Code K.

Item 41 – Enter Code T.

Items 42B-45 – Enter total income of disqualified person.

Item 60 – Enter total shelter expenses.

Item 83 – Enter number of household members not disqualified.

Item 90 – Enter appropriate code for shelter expense.

Also make corresponding entries on Form H1000-C, Secondary Client Input, in Item 216 to identify the reason for disqualification.

C—634.4 Reinstating a Person Disqualified for Intentional Program Violation When the Disqualification Expires

Revision 02-3; Effective April 1, 2002

SNAP

Make minimum entries for certification or changes.

Item 40 – Enter the appropriate code.

Item 41 – Enter the appropriate code.

Item 49 – Make no entry.

Item 83 – Enter number of eligible household members including the person who is no longer disqualified.

C—634.5 Reporting Increases in Household Composition with More than 11 Persons

Revision 02-3; Effective April 1, 2002

All Programs

Use more than one set of forms. In addition to the standard entries on the first Input document, complete Item 04, page 1.

Use a Form H1000-A, Notice of Application, packet. Separate the NOA and the Case Index Card from the packet and destroy, leaving the H1000-A Input and case record copy intact. White out the preprinted application number, enter the case number in Item 01, and make the following entries:

Item 03 – Sequence Number

Item 04 – Page

Item 06 – Budgeted Job Number

Item 07 – Mail Code

Item 09 – Case Name

Items 32-50 – Begin with line "b"

Staple the Input document together and batch as one.

C—634.6 Change of Payee or Caretaker

Revision 02-3; Effective April 1, 2002

TANF

Item 10 – Enter new case name.

Items 32-37 – Enter information about case name if the person was not previously included in the case.

Items 40-41 – Enter code for new case name.

Item 46 – Enter medical effective date for new case name if the person is certified as a caretaker and was not previously included in the case.

Item 33 – Enter # to remove previous individual if the individual is to be removed from the case.

Items 40-41 – Enter new codes if the previous case name is to remain in the case.

Item 131 – Enter type review code.

Item 132 – Enter Code 120.

Enter budget and Item 66 entries for situations with these changes.

C—634.7 Three Months Prior Medicaid – No Gap in Coverage on an Active Case

Revision 05-4; Effective August 1, 2005

TANF

Item 46 – Enter new medical effective date.

Item 131 – Enter the type review code.

Item 132 – Enter reinvestigation Code 107 if sustaining or other codes if raising or lowering.

Item 133 – Enter number of months of prior eligibility.

Item 134 – Enter three months prior application date.

To change a medical effective date for more than six months before the current process month, send a memo with supervisor's approval to State Office Data Integrity (SODI) Section, Systems Control Division, State Office, Y-922, explaining why the information needs to be processed.

C—634.8 Entering the 90% Earned Income Deduction and Child Care to Ensure Automatic Removal of the Deduction

Revision 05-4; Effective August 1, 2005

TANF

Item 42B – Enter gross earned income.

Item 58 – Enter standard work expense deduction. Do not enter childcare or 90% deduction.

To report child care deduction:

Item 149, line 1 – Enter C.

Item 152, line 1 – Enter total child care deduction.

To report the 90% earned income deduction:

Item 149, line 2 – Enter 9.

Item 151, line 2 – Enter the last month of the four month eligibility period.

Item 152, line 2 – Enter the total allowable 90% earned income deduction.

Item 59 – Enter the remainder of Item 57 minus Items 58 and 152.

SAVERR automatically removes the 90% deduction after cutoff in the month before the month entered in Item 151. If the case is denied, SAVERR transfers assistance to Type Program 37 and adds 12 or 18 months to the month in Item 151.

When processing the automatic removal of the 90% deduction, SAVERR notifies the individual and sends the advisor an updated H1000-Bsequence.

SAVERR will not automatically remove the 90% deduction or transfer the case to TP 37 when a case is on hold. If a Form H1000-B, Record of Case Action, is submitted to remove the hold, remove the 90% deduction by entering

- 9 in Item 149, and
- 0 in Item 152.

If denying the case, process a transfer to TP 37.

C-640, Denial Entries

Body

C—641 Denial of a TANF/Medical Programs Application

Revision 02-3; Effective April 1, 2002

TANF and Medical Programs

Item 29 – Action Notice

Item 127 – Type Program

Item 132 – Action Code

C—642 Denial of a SNAP Application

Revision 02-3; Effective April 1, 2002

SNAP

To deny an application of Form H1000-A, Notice of Application, make the following entries:

Item 29 – Enter date Form H1017, Notice of Benefit Denial or Reduction, is sent to applicant.

Item 79 – Enter application code.

Item 91 – Enter denial code.

Item 92 – Enter date of denial.

To deny an application on Form H1000-B, Record of Case Action, make these additional entries:

Item 08 – Enter date applied.

Item 78 – Enter C.

C—643 Hold Code 5 Actions Pending Automatic Grant Denial

Revision 02-3; Effective April 1, 2002

TANF

Item 131 – Enter the type review code.

Item 132 – Enter Code 107. Use Code 110 for Type Program 07 cases.

Item 142 – Enter hold Code 5.

Item 143 – Enter denial code.

Do not enter any budgetary changes

If the hold is not released in the hold effective month, an updated sequence Form H1000-B, Record of Case Action, is produced at cutoff of the hold effective month showing the grant denial.

C—644 Denial of an Active Case Because of Failure to Comply with Employment Services

Revision 02-3; Effective April 1, 2002

SNAP

Item 41 – Enter U for the primary wage earner who did not comply.

Item 78 – Enter type review.

Item 91 – Enter Code 610.

Item 92 – Enter last day of month the denial is effective.

C-700, Reserved for Future Use

C-800, Automated Support Systems

C-810, Texas Integrated Eligibility Redesign System

Body

C-811 Case Number and Eligibility Determination Group (EDG) Number

Revision 15-4; Effective October 1, 2015

All Programs

A case is defined as a group of persons who are seeking benefits together for at least some, if not all, of the members of the group. Members included on the case may or may not be certified to receive benefits. Each case is identified by a 10-digit case number. A TIERS case can include multiple EDGs. An EDG is defined as members of a household whose needs, resources, income, and deductions, as applicable by program, are considered in determining eligibility for benefits. Each EDG is identified by a nine-digit EDG number.

Example: If a household is approved for Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), assign one EDG number for TANF and another EDG number for SNAP.

Case numbers are kept indefinitely and should be reassigned when the household reapplies for any program.

Note: There may be instances when a new case number may be required, such as for a person leaving a drug treatment facility or for foster care cases.

Related Policy

Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP), B-475

C-812 Individual Number

Revision 15-4; Effective October 1, 2015

All Programs

The first time a person is approved for Texas Health and Human Services Commission (HHSC) services or benefits, TIERS assigns an individual a unique number. Advisors use the same number, called the individual number, for that person for all programs.

Individual numbers are kept indefinitely and should be reassigned when the individual reapplies for any program.

C-813 Hierarchy of Individual Identification Data

Revision 15-4; Effective October 1, 2015

All Programs

Before approving an applicant who already has an individual number, advisors must compare information in TIERS inquiry to the information in the case record. Advisors should note and clear any discrepancies with the individual.

TIERS retains only one set of identification information for each individual. The advisor must make changes according to the hierarchy. The following priority applies:

- A program area providing benefits to an individual takes precedence over a program area not providing benefits. For example, TANF caretaker information takes precedence over TANF payee information, and an active case takes precedence over a denied case.
- For name and birth date identification data:

Priority is given to ...	**over ...**
Medical Programs	TANF
TANF	Supplemental Security Income (SSI), SNAP, SAS*
SNAP	SAS*

- For sex and race identification data:

Priority is given to ...	**over ...**
Medical Programs	TANF, SSI, SNAP, SAS*
TANF	SSI, SNAP, SAS*
SNAP	SSI, SAS*
SSI	SAS*

* SAS is Long Term Care's Service Authorization System. Long Term Care authorizes payments to its service providers using this system.

Note: If the Social Security Administration (SSA) validates the Social Security number (SSN) or claim number, the advisor cannot change the number in TIERS. Document the incorrect SSN in the Request Merge/Separate record, if requesting a merge/separate. Use the existing number on file and report the correct number by memorandum to State Office Data Integrity (SODI) Section, Long Term Care, State Office, Y-922.

Before approving an applicant in another program area, check TIERS for accuracy of identifying information. If the identifying information is incorrect, enter the correct information in the **Individual Household** Logical Unit of Work (LUW) or other applicable LUW in TIERS.

C-814 Merge and Separate

Revision 25-4; Effective Oct. 1, 2025

All Programs

Staff should use the functional area on the left navigation bar titled **Merge/Separate** to request a merge or a separate.

Select **Request Merge** if a person was assigned more than one individual number. Follow the steps below.

- Enter a minimum of two and up to 10 individual numbers to be merged. Enter mandatory comments explaining the reason for the merge request.
- Click the **Add** button. The demographic information associated with that individual number shows in the **Selected Individuals** section. If it is not the correct person, delete the entry using the **Delete** icon or use the **Binoculars** icon to search for the person using the demographic data, like the individual search in **Inquiry**.
- Once the individual numbers and mandatory comments are entered, click the **Submit** button to send the request to HHSC CCC Data Integrity.

Select **Request Separate** when more than one person is assigned to a single individual number. Follow the steps below.

- Enter one shared individual number and up to three individual numbers to be separated. Enter mandatory comments explaining the reason for the separate request.
- Enter the individual number or demographic information and click **Add**. The demographic information associated with the individual number will display in the **Selected Shared Individuals** and **Shared ID above is to be separated to these individuals** sections. If it is not the correct person, delete that entry using the **Delete** icon or use the **Binoculars** icon to search for the person using demographic data, like the individual search in **Inquiry**.
- Once all the individual numbers and mandatory comments are entered, click the **Submit** button to send the request to HHSC CCC Data Integrity.

TIERS will not allow the submission of a merge or separate request for an individual number when a merge or separate request already exists and will display a validation message. When TIERS displays a validation message, correct the information if entered incorrectly or use the **Search Merge/Separate** function to determine if the individual numbers requested are associated with the same individual number.

Use **Search Merge/Separate** to track the progress of the request. Some requests will take longer than others. Some individual numbers have to age off of an EDG due to the denial effective date. HHSC CCC Data Integrity staff can mark an individual number as a Potential Duplicate (PD) when a merge or separate request is made. Staff cannot select an individual number for addition to new cases if it is marked as PD, which limits the potential for the wrong individual number to be awarded benefits or coverage in error.

Send questions concerning a merge or separate request to the HHSC CCC Data Integrity Program mailbox.

C-815 TIERS Case Modes

Revision 14-1; Effective January 1, 2014

A TIERS case mode is a particular mode that TIERS uses to determine the sequence of LUWs it presents during Data Collection. The case mode is typically determined by the type of action being taken on the case, for example, *Intake* (new application), *Complete Action* (redetermination), *Change Action* (processing a change), and so on. Staff set the case mode in the **Data Collection – Initiate Interview** page. Staff should check the case mode prior to starting a case by performing inquiry. Inquiry displays the current case mode and the employee number of the advisor currently assigned the case. The current case mode is also displayed at the top of each page in Data Collection.

C-815.1 Case Mode Definitions

Revision 15-4; Effective October 1, 2015

All Programs

There are 16 case modes.

Mode	Definition
Case Reading	Authorized staff use this mode to examine certain information for a case and record results online.
Change Action	Used to make changes to a case when no application is required.
Complete Action	Used for redeterminations and reviews or applications for a new program for an individual in an existing case.
Continue Previously Selected Mode	Allows staff to access Data Collection in the mode previously used.
Conversion	The case mode that System for Application, Verification, Eligibility, Referrals, and Reports (SAVERR) cases and Children's Health Insurance Program (CHIP) cases were converted to if there was mismatched data. This mode is utilized by authorized staff.
Intake	Used when the household is requesting assistance for the very first time or for an existing case when all of the EDGs are denied.

Mode	Definition
Ongoing	Ongoing mode provides read-only access to all LUWs. **Exception:** Changes can be made in Ongoing mode to the **Household Address – Details** page and the **Initiate Interview – Initiate Review** page. In these two areas, updates can be made without running Eligibility Determination Benefit Calculation (EDBC) and then having to dispose all EDGs. Used with start date and end date fields on the Initiate Interview page to view historical records for a specific time period.
Periodic Income Check (PIC)	Used when a client returns information requested in a missing information request during a PIC.
Reopen	Used when an advisor reopens a case (no active EDGs) and it has been more than 30 days since the last denial action.
Reopen-Left Navigation	Used when the advisor reopens a case (no active EDGs) and it has been 30 days or less since the last denial action.
SSI Certification	This mode is used by State Office Data Integrity staff to approve SSI Medicaid.
SSI Manual Create	Allows authorized staff to establish SSI eligibility in TIERS for an individual when the individual is newly eligible for SSI, or when an SSI-eligible individual has moved from another state and the record is not yet available through the TIERS interface with State Data Exchange (SDX).
Second Level Review	Used when a second level review is required. The staff member must be authorized to perform second level reviews on TIERS cases.
Special Review	Used when a case or EDG requires a review or reauthorization of services that falls outside the normal redetermination time frames.
Spousal PRA	Allows authorized staff to record information and determine the Spousal Protected Resource Amount (SPRA) for institutional and waiver programs.

C-816 Case Mode Hierarchy

Revision 14-1; Effective January 1, 2014

All Programs

Complete Action and Intake modes have hierarchy over all other modes. When an advisor is working on a case in Complete Action or Intake mode, other staff can enter information in TIERS, but they cannot send notices or dispose the case. Their actions are disposed only when the advisor working in Complete Action or Intake mode disposes the case. If an advisor has the case in Change Action mode and subsequently a different advisor accesses the case in Complete Action mode, the Change Action advisor can continue to enter information in the case, but the Complete Action advisor is the only one who can dispose the case and send notices.

Once an advisor accesses a case in Complete Action mode, all individual-initiated changes go to that advisor until the case is disposed. In addition, once an advisor begins an individual-initiated change, all subsequent individual-initiated changes will go to that advisor until the case is disposed. However, outstanding alerts assigned to someone else do not automatically transfer to an advisor who begins a new action on a case.

Note: TIERS routes agency-generated changes based on the office profile.

C-817 Electronic Data Sources (ELDS)

Revision 15-4; Effective October 1, 2015

All Programs

Information from ELDS, such as State Online Query (SOLQ), is presented to advisors in TIERS during Data Collection to allow the advisor to use it as verification. If verification is not available through ELDS in Data Collection, advisors must attempt to verify using other electronic sources (i.e., Data Broker) before requesting additional information or documentation from the applicant.

Advisors must receive written or verbal consent for any adult age 19 or older that is included on an application or renewal and whose information is needed to make an eligibility determination before:

- requesting information from electronic data sources, such as Data Broker or SOLQ; or
- using the individual's information from TIERS, if that adult has a case with HHSC (SNAP, TANF, Medicaid or CHIP).

When consent is given, advisors may use ELDS, a Data Broker report, and/or information from a known case.

If the advisors cannot obtain consent to use ELDS, Data Broker, or existing HHSC data, advisors must deny the application for the individual whose eligibility is being determined.

SNAP and TANF

The signature of the person submitting the application or renewal provides permission for all household members.

Medical Programs

The signature of the person submitting the application or renewal provides permission for any adult listed in A-121, Receipt of Application. For individuals not listed in A-121, advisors must attempt to contact the individual whose permission is needed by phone or via Form H1213, Children's Health-Care Benefits: More Facts Needed from the Parent Who Has Custody.

Example: If a non-custodial parent applies on behalf of a child, information, such as income from the custodial parent, may be needed from the custodial parent to determine that child's eligibility. Advisors must call and obtain verbal consent from the custodial parent before pulling electronic data on that individual, even if the custodial parent's information is available in the system. If the advisor cannot get consent from the custodial parent, the advisor must request the missing information needed from the custodial parent using Form H1213. If the custodial parent does not provide consent to use electronic data, the advisor must deny the child's application.

Related Policy

Verification Requirements, A-1370
How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income, A-1355.2

C-820, Data Broker

Body

Revision 23-4; Effective Oct. 1, 2023

All Programs

HHSC contracts with a Data Broker vendor to provide financial and other background information about SNAP, TANF and Medical Program applicants and recipients. The vendor collects and combines information from several data sources into one report. This report is called a Data Broker Combined Report and includes information such as residential address, people living at that address, vehicle ownership, employment, income verification and other information. Within each Data Broker Combined Report, there is an option to request a credit report on the person for whom the Data Broker report was requested.

TIERS requests the Data Broker Combined Report in the **Individual Household** logical unit of work (LUW) in any mode, other than Ongoing. The Data Broker Combined Report and individual data searches are accessible using the Data Broker Portal.

Follow questionable information policy to resolve discrepancies between Data Broker information and information the applicant or recipient provides. To clear discrepant information:

- contact the household and allow the person to explain the discrepancy; or
- send the household Form H1020, Request for Information or Action, asking for information or verification to resolve the discrepancy.

Federal law limits the use of credit reports to permissible purposes.

Note: Do not request a credit report before the initial interview. If applicable, the request must be made during the interview.

Use the charts below to determine when to request a Data Broker Combined Report, with or without credit information:

Request a Data Broker Combined Report *Without* a Credit Report at:

For TANF, SNAP, One-Time TANF, TP 08, TP 33, TP 34, TP 35, TP 43, TP 44, TP 48 and CHIP **Applications and Redeterminations**	for household members 16 and older.
For SNAP **Changes when adding a household member 16 or older**	for household members 16 and older.

Request a Data Broker Combined Report *With* a Credit Report at:

All Programs **Applications, Redeterminations, Changes – New Household Members**	for household members 16 and older on **any** EDG when permissible purpose exists and a credit report is needed to: • authenticate a caller;

Request a Data Broker Combined Report *With* a Credit Report at:

- help clear questionable information; or
- clear discrepant information in the EDG. An example of discrepant information is when a person has more than two months of negative management.

Use the prudent person principle to decide the need for a Data Broker report or credit report in these instances.

Notes:

- Data Broker Combined Reports with or without credit reports are not required for households that apply for or receive SNAP-CAP. If needed, staff may request either a Data Broker Combined Report for verification or a Combined Report with a credit report to resolve discrepancies in reported information, such as negative management.
- For independent children or child-only EDGs, request a Data Broker report on the child only if staff believe there are unreported assets as applicable by program, income or other information that would affect the child's eligibility.

For reported changes, use the interactive search feature in the Data Broker Portal to request a specific type of report based on the reported change. Use the Data Broker Portal to access the following acceptable verification sources:

- Department of Public Safety (DPS);
- United States Citizenship and Immigration Services (USCIS);
- Texas Department of Motor Vehicles (DMV);
- OAG
- TWC;
- Texas Lottery Winnings;
- Federal Data Services Hub (FDSH) The Work Number (TWN) data;
- Department of State Health Services (DSHS);
- SNAP Electronic Disqualified Recipient System (eDRS);
- Electronic Benefits Transfer (EBT); and
- Texas Department of Criminal Justice (TDCJ).

These verification sources provide information on:

- people search information such as name, address, driver license or ID and neighbors;
- alien verification;
- vehicle search including name, address, license plate, vehicle identification number and vehicle valuation;
- income search including new hire, quarterly wages and unemployment insurance benefits, child support and Texas lottery winnings;
- earned income and employment information TWN data;
- marriage and divorce;
- SNAP disqualifications;
- out of state shopping via EBT card transactions for SNAP, TANF or both; and
- Texas criminal history.

Review the Data Broker reports to accurately determine eligibility and clear any found discrepancies. Failure to review the report may result in eligibility errors that can lead to quality control errors.

Related Policy

Permissible Purpose, C-824
Questionable Information, C-920

C-821 Access Permission

Revision 19-4; Effective October 1, 2019

All Programs

New Users — Through the HHS Enterprise Portal, supervisors or managers complete and submit Form 4743, Request for Applications and System Access, for each employee who needs access to the Data Broker system. Managers obtain a signed Data Broker Security Agreement, TWC Security Agreement, and OAG Security Agreement form for each employee who needs access. In the comment field of Form 4743, the supervisor or manager notes the dates each of the three Security Agreements were signed. Once added to the system, staff receives an email with a temporary password link and further instructions. The Data Broker temporary password link expires within 48 hours from receipt of provisioning email. If the temporary password link expires before staff creates an initial password, staff can request a new temporary password link by selecting the “Forgot Password” link in the Data Broker Portal login screen.

Note: New staff must access the Data Broker system within 45 days of the Data Broker account creation or the system automatically deactivates the account.

Inactive Users — All provisioned staff must access the Data Broker system via the Data Broker Portal or through TIERS at least every 90 days, or the system deactivates access. Once the system has deactivated access, staff must submit a new Data Broker request through the HHS Enterprise Portal. Once staff has been reactivated, they must again complete the required User Access and Fair Credit Reporting Act (FCRA) trainings to use the Data Broker system.

C-822 Data Broker Passwords

Revision 19-4; Effective October 1, 2019

All Programs

Users are directed to the User Options page to create a unique password. Staff can change their password at any time by clicking on the “User Options” field located on the left navigation section in the Data Broker Portal. Staff are required to enter their current password, new password, and confirmation of their new password.

Staff who have forgotten their password can use the “Forgot your Password?” link located on the sign-in page of the Data Broker Portal. A temporary password link is emailed to the address associated with the staff’s account.

C-823 Login Procedures - Data Broker Portal System

Revision 19-4; Effective October 1, 2019

All Programs

This is where you can access the stand-alone Data Broker Portal system. To log on, the staff must enter their User ID which is their 11-digit employee identification number, and a unique password and then click “Login.”

Staff must complete the following steps before gaining access to the Data Broker System:

- create a new password for the Data Broker system;
- log in to the Data Broker system; and
- complete the User Access and Fair Credit Reporting Act (FCRA) trainings.

Notes: The User Access and FCRA trainings are located within the Learning Management System. Staff are directed to these trainings when they login for the first time.

Once the required trainings are completed and staff logs into the Data Broker system, they must read the information and click "I understand the above and agree" to acknowledge that they understand the Data Broker information can only be used for business purposes and is confidential.

Staff must also read the agreement and click "I understand the above and agree" in the “Authorization for Access to Request Credit Report” to acknowledge that they have been adequately trained on the FCRA and agree to only request a credit report when permissible purpose exists.

If staff clicks "I disagree" to either screen, they will not gain access to the Data Broker system or credit reports.

C-823.1 Frequently Asked Questions and Data Broker User Guide

Revision 19-4; Effective October 1, 2019

The Data Broker Frequently Asked Questions (FAQs) and the Data Broker User Guide are located under the “Training” section on the left navigation menu within the Data Broker Portal. These documents provide answers to frequently asked questions about Data Broker. The documents include instructions and sample screens to assist staff with understanding the different types of reports available in the Data Broker system.

The FAQs and Data Broker User Guide can be found in the Data Broker Portal.

C-824 Permissible Purpose

Revision 19-4; Effective October 1, 2019

All Programs

The Fair Credit Reporting Act (FCRA) covers access to and use of credit reports. The FCRA permits staff to request credit information for persons to determine eligibility. Staff may not request credit information for purposes other than to determine eligibility. The FCRA requires permissible purpose before staff can legally request a credit report.

Permissible purpose means the person whose credit report is requested must be:

- an applicant or a certified TANF, SNAP or Medical Program household member (or a member who would be certified but is disqualified); or
- a Medical Program MAGI household member.

Note: Do not request a credit report:

- on a payee EDG unless the responsible relative is the child's parent; or
- using an invalid Social Security number.

The FCRA makes a clear distinction between requesting credit reports and other types of inquiries made through Data Broker. Under legal statutes, staff may request identifying information such as address, employment and vehicle registration on any person.

Permissible purpose is not required when requesting non-credit identifying information. For example, if staff suspect an absent parent is in the home, staff do not have permissible purpose to request a credit report on the absent parent. However, it is appropriate to request identifying information available through the Data Broker system.

Note: Those who request information without permissible purpose are in violation of federal law and are subject to fines.

C-825 Data Broker Combined Report Sources

Revision 19-4; Effective October 1, 2019

All Programs

This section describes the various data sources in the Data Broker Combined Report that are not subjected to permissible purpose requirements noted in section C-824, Permissible Purpose.

C-825.1 Driver License Information

Revision 19-4; Effective October 1, 2019

All Programs

Data Broker matches information from the Combined Report Search screen against the Texas Department of Public Safety (DPS) data. When a match is found, DPS data is pulled into the report. Information in this report may identify discrepancies in the identity and residence address of the person. This report includes a person’s sex, race, height, hair color, eye color, name, date of birth, address, and any previous names or addresses. Because DPS re-issues driver’s licenses and ID numbers approximately two years after the driver license and ID number expires, previous names and addresses associated with that number are listed in this section when applicable.

The Validated field displays the date DPS last updated the driver’s license or ID information.

Note: DPS updates information on this report only when the person with a Texas driver license (TDL) or DPS ID provides updated information to DPS.

C-825.2 Persons at Entered Address

Revision 19-4; Effective October 1, 2019

All Programs

Data Broker searches the DPS database and pulls records for all persons listed at the address entered on the Combined Report Search screen. The information pulled includes each person's name, address, and date of birth (DOB). Previous residents may appear if they have not changed their address with DPS.

Information on this report is useful in providing case clues about household composition and exploring parental absence for deprivation.

C-825.3 Neighborhood People Search

Revision 19-4; Effective October 1, 2019

All Programs

This report lists residents located in the 20 addresses nearest the address entered on the Combined Report Search screen. This information may be useful as a case clue for locating absent parents or other case-related activities.

Data Broker pulls this information from the DPS database. The information is only as current as DPS's most recent update. Some persons may have both a Texas ID and a Texas Driver's License (TDL). These persons appear on the report for each Texas ID and TDL.

Note: Staff may contact a neighbor on the Data Broker report only when:

- the person has allowed staff to do so; or
- information is received from another source that contradicts the person's statement(s).

See C-920 Questionable Information, and C-930 Providing Verification, for information regarding contacting a collateral source not allowed by the person.

C-825.4 Out-of-State Shopping (OSS) Report

Revision 19-4; Effective October 1, 2019

TANF and SNAP

The Out-of-State Shopping (OSS) Report lists households receiving SNAP or TANF benefits in Texas that:

- shopped out of state in the last 60 days;
- did not shop in Texas within a 60-day period; and
- have active EDGs.

The OSS Report is included on the Data Broker Combined Report and is considered a case clue that Texas residency may be questionable. Address OSS information at renewal, reapplications and at a change.

Related Policy

Advisor Action on OSS Report Activity, B-353.1
Out-of-State Shopping (OSS) Reports, B-353
Verification Requirements, A-760
Verification Sources, A-761

C-825.4.1 Clearing Non-Border OSS Report Activity at a Complete Action

Revision 19-4; Effective October 1, 2019

TANF and SNAP

At a Change Action

Send the household Form H1020, Request for Information or Action, to request verification of the household's address.

Exception: It is not required to clear Non-Border OSS activity when the household's most recent OSS activity occurred in the:

- month prior to the periodic review month or the periodic review month for TANF; or
- next to the last benefit month or the last benefit month for SNAP.

At a Complete Action

The household must provide verification of their address if the:

- most recent OSS activity occurred within six months before the interview/desk review month, and
- OSS activity listed in the report was not previously cleared.

Refer to chart in B-353 Out-of-State (OSS) Reports, for appropriate action after a household has been asked to provide verification of address.

Note: Take action on any associated Medical Program EDG when clearing any OSS report activity.

Related Policy

Out-of-State Shopping (OSS) Reports, B-353
Verification Requirements, A-760
Verification Sources, A-761

C-825.4.2 Clearing Border OSS Report Activity at a Complete Action

Revision 19-4; Effective October 1, 2019

TANF and SNAP

This report must be cleared when a household submits an application or redetermination or at a change action and the OSS activity in the report makes the household's address questionable. Clearance depends on the facts in the situation.

Example: A household living in Texas near the Arkansas border and shopping in Arkansas may not cause residency to be questionable. A household living in Austin and shopping only in Arkansas in the past 60 days could be considered questionable.

Note: Act on any associated Medical Program EDG when clearing any OSS report activity.

Related Policy

Out-of-State Shopping (OSS) Reports, B-353
Verification Requirements, A-760
Verification Sources, A-761
Questionable Information, C-920

C—825.5 Texas Vehicle

Revision 19-4; Effective October 1, 2019

TANF, SNAP, Children on TP 32, and Children on TP 56

The Data Broker searches the Texas Department of Motor Vehicles' (DMV) database and obtains information for all vehicles listed at the address entered on the Combined Report Search screen. Information obtained includes the:

- owner of each vehicle;
- Texas vehicle license tag number;
- year, make, and model of each vehicle;
- average wholesale value of the vehicle; and
- vehicle's lien holder (when available on DMV records).

This information is useful when exploring a household's resources. The information provides case clues on vehicle ownership, value and household composition. Staff must explore and clear discrepancies.

Except for vehicle values, Data Broker receives updated information weekly from the Texas DMV database. Data Broker updates vehicle values monthly. Vehicle values are obtained through the National Automobile Dealers Association (NADA) book. Texas DMV updates its database when a person renews a vehicle's registration, retitles a vehicle, or reports a change of address to Texas DMV. It is possible for vehicles not owned by the household to appear on this report. This can happen when a person does not complete a title transfer or does not update an address with the Texas DMV.

Vehicles registered at an address, other than where the person lives, do not appear on this report. When a person has a vehicle not shown on the report, staff can use the owner's name, the vehicle license plate number, or the vehicle identification number (VIN) to obtain information by using the Vehicle Search option listed on the left navigation menu of the Data Broker Portal.

The value field lists the average wholesale value of the vehicle and can be used as verification to determine the countable value of the vehicle. See A-1251, Verification Sources, for other acceptable methods of verification.

C-825.6 Reserved For Future Use

Revision 19-4; Effective October 1, 2019

C-825.7 Reserved For Future Use

Revision 19-4; Effective October 1, 2019

C-825.8 Reserved For Future Use

Revision 19-4; Effective October 1, 2019

C-825.9 Texas Marriage and Divorce

Revision 19-4; Effective October 1, 2019

All Programs

This report is pulled from marriage and divorce records from the Texas Department of State Health Services (DSHS) Texas Vital Statistics Unit. It is only available via an interactive inquiry in the Data Broker Portal. Although this report is updated annually, the marriage and divorce data is delayed by three years. The records do not contain information for the most recent three years.

The report provides the dates and names of people married and divorced in Texas. The names shown on the marriage and divorce reports are the names provided to DSHS on the marriage and divorce documents.

If a person changes their name, staff may need to search using the prior held name to find records. Information from this report is not included on the combined report.

C-825.10 Texas Criminal Convictions

Revision 20-4; Effective October 1, 2020

TANF, SNAP and One-Time TANF

The Texas Criminal Conviction report contains a list of all convictions and felony deferred adjudications that are contained in the digital criminal history system maintained by Texas Department of Public Safety (DPS).

The information included in the report depends on the authority reporting the offense and is considered a case clue only.

In most cases, the report includes the classification of the offense (felony, misdemeanor, deferred adjudication, etc.).

The report lists several pieces of identifying information including DOB, sex, race, hair and eye color, height and weight. When a criminal record is found, check each factor to ensure the person on the report is the person on the EDG.

When the report reveals information that indicates the person may have committed an offense subject to action by HHSC, explore the situation with the person. If the person acknowledges they are the person on the report, take the appropriate action.

If staff have reason to believe that the person is the person indicated on the report, but the person disagrees or disagrees with other information contained within the report (such as the type of conviction or whether it was a felony or misdemeanor):

- document the person's response in the Case Comments;
- proceed with the appropriate EDG action without acting on the criminal history report;
- contact the Office of Inspector General (OIG) by emailing OIG Benefits Program Integrity (BPI); and
- document the reason for contacting OIG in the Case Comments.

Once OIG obtains information to clear the discrepancy, the assigned OIG BPI investigator provides the information via email. Staff responsible for clearing this task must document the results of the OIG BPI's findings in Case Comments and, if appropriate, enter information in the **Data Collection-Individual Demographic-Conviction/Rehabilitation** page. Make an overpayment referral if appropriate.

This report is updated monthly. However, since it contains records reported to DPS by various Texas courts, the report may not be complete. When it is incomplete, staff will investigate further.

Related Policy

Who Is Not Included, A-222
Disqualified Persons, A-232.2
SNAP — Budgeting for Persons Disqualified for Intentional Program Violations, SNAP Employment Services Noncompliances, Felony Drug Convictions or Being a Fugitive, A-1362.4
Alcohol or Drugs, A-2128
When the Individual Signs Form H1073, A-2128.1
Filing an Overpayment Referral, B-770

C-825.11 Reserved for Future Use

Revision 20-4; Effective October 1, 2020

C-825.12 Employer New Hire Report (ENHR) and National Directory of New Hires (NDNH) Report

Revision 19-4; Effective October 1, 2019

All Programs

The ENHR and NDNH reports contain information used as an indicator of unreported earned income. Data Broker displays new hire data from 180 days prior to the date the report was requested up to the current date.

The ENHR contains employer information for people whose employers are based in Texas. The NDNH contains employer information from all 50 states, four territories, and all federal agencies.

These reports provide information such as hire date, employer name and address, and employee name, date of birth and address.

The ENHR and NDNH reports may list the corporate name and address instead of the local business name and address. Consider that the commonly known name of a business may be different from the corporate name.

Related Policy

Changes, B-600
Verification and Documentation, C-900
Questionable Information, C-920

C-825.13 Texas Workforce Commission (TWC) Wages and Benefits

Revision 25-4; Effective Oct. 1, 2025

All Programs

TWC Wages and Benefits information is available through the interactive and combined Data Broker report options and includes information on wages, claimants, and unemployment insurance benefit (UIB) records. Claimant and UIB payments will display only if the person has applied, is receiving or has received UIB from TWC.

The TWC information is obtained in Data Broker using one of two methods.

1. **Interactive Search** allows the user to search TWC information using the TWC Quarterly Wages and Unemployment Insurance Benefits (UIB) link from the left navigation bar in the Data Broker Portal. Four search criteria are identified:

- Claimant Status
- Wage Details
- Benefits
- Combined Wages, Status, Benefits Report

Complete individual searches using any of the first three criteria. Selecting the Combined Wages, Status, and Benefits Report search criteria will return a combined report of all three TWC inquiries.

The date filter option is available for the user to request TWC inquiries for any of the four search criteria. Date filter options include two months, four months, six months, one year, two years, three years or all available.

2. **The Standard Combined Report** includes the TWC information along with all other reports available.

TWC information returned on the Standard Combined Report defaults to the last two years of data available for wage detail, claimant and benefit payments. If the user needs more than two years of data, use the interactive search in the Data Broker Portal.

The following codes appear within the Claimant Status Search and the Combined Wages, Status, Benefits Report:

- **Clm Sta —** current status of the claim
  - COMPLETE = is valid and complete
  - INCOMPLETE = is missing required information
  - VOID = is voided
  - BATCH = claimant must complete and activate the claim
- **Clm Sta DT —** date the claim status last changed
- **Pgm —** the program under which this claim is filed

    - EUC = emergency unemployment
    - EXB = extended benefits
    - REG = regular unemployment insurance
    - TRA = trade affected unemployment insurance
    - TRX = extended trade affected
    - TUC = temporary unemployment
- **Clm Dt —** the Sunday effective date of this claim
- **Pay St —** the two initials of paying state
- **File Dt —** the date the claimant filed their claim
- Last employer's name and address
- **WBA —** the weekly benefit amount
- **MBA —** the maximum benefit amount
- **Balnc —** the current benefits remaining
- **PaiD —** the total amount of benefits paid
- **Pend Invstn —** if TWC is investigating this claim. If yes, the person's benefits may be delayed. Y = Yes, N = No
- **BWE —** ending date of the benefit week, it will always be a Saturday because TWC starts a new week on Sunday
- **OP —** amount overpaid that week
- **Status —** the status code of each certification
    - AA = bad address
    - AG = agent state certification
    - AR = system error – notify te
    - CV = converted benefit week
    - DQ = disqualified
    - EE = excessive earnings
    - EH = excessive hours
    - FP = first payment
    - FR = fraud
    - FV = fraud voided by appeals
    - GM = good money or accounting
    - IC = open investigation
    - IE = ineligible
    - IN = incomplete investigation
    - IW = waiting week identified
    - NC = response not certified
    - OP = overpaid
    - OR = overpayment reversed
    - OV = overpayment voided
    - PD = processed
    - PP = pending processing
    - PR = pending employer response
    - RC = recovered
    - RP = partial recovery
    - SP = suppression period
    - VC = voided claim
    - WW = served waiting week
    - XX = forced pay
    - YY = offline pay
    - ZZ = pay old claim
- **TotDist —** sum of any recovered overpayments, child support payments and all other distributions for that week
- **TotDedc —** sum of any child support deductions and all other deductions for that week
- **PmtAmt —** amount of benefits issued to the claimant after any withheld for an overpayment recovery, child support or income tax. This amount may be less than the WBA.

The following codes appear within the Benefit Payments Search:

- **BWE —** ending date of the benefit week, it will always be a Saturday because TWC starts a new week on Sunday.
- **File Date —** the date the claimant filed the claim
    - V = filed by phone
    - P = filed by paper
- **Week Sts —** the status code of each certification
    - CV = convert benefit week
    - DQ = disqualified
    - EE = earning adjustment
    - FP = first pay
    - IC = payment flag is "NO"
    - IE = ineligible and will not receive benefits
    - IN = investigation pending, no payment

    - IW = identified waiting week; will not be paid until claimant receives two times the weekly benefit amount and has returned to full-time employment after being totally or partially unemployed for at least seven consecutive days or has exhausted the claimant's regular benefits for the current benefit year, other than benefits applicable to the waiting period.
    - NC = not certified
    - PD = paid
    - PP = pending payment
    - PR = pending for employer's response
    - PROCESSED = this claim is processed
    - WW = waiting week served and paid
- **Op Amt —** amount of UI overpayment, if any
- **Ernings —** amount of wages the claimant earned during this week, if any
- **Pgm —** program under which this claim is filed.
    - EUC = emergency unemployment
    - EXB = extended benefits
    - REG = regular unemployment insurance
    - TRA = trade affected unemployment insurance
    - TRX = extended trade affected
    - TUC = temporary unemployment
- **Ddct —** sum of any child support deductions and all other deductions for that week. A deduction is a reduction in the weekly entitlement or amount benefiting the claimant. An example would be a reduction in benefit payment because the claimant receives retirement payment from a qualifying employer.
- **Dist —** sum of any recovered overpayments, child support payments and all other distributions for that week. A distribution is a benefit to the claimant but distributed to an entity other than the claimant. Examples of a distribution would include child support payments, IRS withholdings or overpayment absorption.
- **Amt —** amount of benefits issued to the claimant, after any withheld for an overpayment recovery, Child Support or income tax.
- **Date —** date the benefits were issued to the claimant.
- **ID —** warrant number of this benefit payment. Payment is made by warrant, direct deposit and debit card. The method of payment is indicated by the first character of the payment ID. Codes include:
    - B = direct deposit
    - D = debit card
    - W = TWC warrant

A message with No records found displays if no information is available for a person.

Related Policy

Data Broker Combined Reports Sources, C-825

C-825.13.1 TWC Error Messages

Revision 19-4; Effective October 1, 2019

All Programs

An error message may appear when a request is made and the TWC database is unavailable.

When a TWC inquiry is requested and an error is returned, the Table of Contents of the Data Broker Combined Report will display the following message next to the TWC header:

"Request timed out. Please click here to retry again."

By clicking on this link, staff can re-request the report without re-entering the person's information. Staff should continue to retry until the information becomes available.

C-825.14 Office of the Attorney General (OAG) Child Support

Revision 19-4; Effective October 1, 2019

All Programs

This report contains child support data from the OAG's database. Data Broker searches the OAG database and pulls records for the person entered on the Combined Report Search screen and displays all people receiving and paying support payments associated with that person.

The OAG information available through Data Broker allows staff to obtain child support income that may not be listed on Form H1010, Texas Works Application For Assistance – Your Texas Benefits, or otherwise reported, reducing the risk of fraud and quality control payment errors.

Additionally, Data Broker offers household composition case clues by listing an address for each member, if available, on the combined report associated to a particular OAG case.

This report is also available via an interactive inquiry in the Data Broker Search Options menu to conduct a member or financial search.

- A member search is used when the case name or adult household member's Social Security Number (SSN) is not available.
- A financial search can be done for specific financial information for a period not found on the Combined Report Search.

Note: The Texas Child Support Enforcement System (TXCSES) web-based system is available for limited use, if needed, to obtain information not found within the Data Broker system.

Related Policy

Accessing Texas Child Support Enforcement System (TXCSES), C-832.1

C-825.14.1 OAG Child Support Data

Revision 19-4; Effective October 1, 2019

All Programs

Child support data may be provided in some or all of the six fields below for each report:

- **Collections** – current child support, medical support, dental support, spousal support, and arrears from the person for whom the Data Broker inquiry was requested.
- **Disbursements** – current child support, medical support, dental support, spousal support, and arrears to the person for whom the Data Broker inquiry was requested.
- **Obligated Support** – reported for both collections and disbursements.
- **Member Details** – includes all members associated with the child support case.
- **Unknown Payments** – payments made to a person when the type of payment is unknown. When unknown payments exist, explore the payment type with the person.
- **Family Violence Indicator** – the child support record in Data Broker will have a family violence indicator when family violence is indicated by OAG.

Note: If staff discover payments or the person states they have received payments not listed in Data Broker, access the Texas Child Support Enforcement System (TXCSES) to verify these payments and obligations. If the necessary information is not available in TXCSES, pend for verification.

Case is a 'registry-only' case, which means that not all obligations nor dependents may be listed.

The Data Broker OAG screens contain a detailed breakdown of the following information:

- **The reports are member-oriented instead of case-oriented.** The report contains details from all child support cases associated with the person (member), including both collections and disbursements. If the person receives disbursements from multiple absent parents (AP), the payments from each AP are displayed separately within each report.
- **The report displays collections and disbursements.** Payments from all child support cases associated with a particular person will be displayed in the report.
- **Support order obligations are sorted per dependent.** Legal obligations typically reflect a monthly amount. The Obligated Support section is displayed to inform staff of the **legally** obligated amount.

  The Per Period Amount column under the Obligated Support section displays the total obligated amount for all children of an absent parent. The Per Child Amount displays each child's portion of legally obligated support. If there is only one child, then the amounts in the Per Child Amount and Per Period Amount columns will be the same. If there are more children, the sum of all the Per Child Amounts will be reflected in the Per Period Amount column.

  The Duration column displays the period for which the legal obligation applies. The child support order establishes the begin date and end date of the legal obligation. Orders normally end once the child turns 18 or graduates from high school, if later, although obligations may continue past this date due to a child's disability. When the obligation includes more than one child of a different age and the obligation ends for a child, a new duration period will be reflected in the duration field. If at any time the AP becomes delinquent in payments, child support and medical arrears can be ordered in addition to the amount the AP is originally ordered to pay, and this may prolong the AP's obligation duration period.

Note: Payments (collections and disbursements) are sorted by support type (e.g., child support vs. medical support).

- **Disbursement Payments are sorted by dependent.** The Data Broker child support function automatically calculates and sorts the payment information for each dependent on the case when a single payment is made for more than one dependent.

  The Per Child Amount column displays the amount to be entered into TIERS for each dependent listed in the Dependents column. Data

Broker reports payments disbursed for a child under the dependent's name even if the child is not in the household. If a caretaker receives current child support for a nonmember (or a member who is no longer in the home) but uses the money for personal or household needs, count it as unearned income as required by policy in A-1326.2, Child Support. Staff must not count the amount used for or provided to the nonmember for whom it is intended to cover. Verify what the person is doing with the payments and what amount must be counted.

Note: Legal obligations are typically established as a monthly obligation. Wages are typically garnished based on the pay frequency of the AP's job. Therefore, the amounts shown on the screens for collections and disbursements reflect the frequency for which the OAG receives the payments, which is usually other than monthly.

For additional policy information on child support payments and how they are allocated for members and non-members, refer to A-1326.2, Child Support.

- **Disbursement Received dates are calculated by Data Broker and displayed in the report.** Data Broker automatically applies the policy in A-1326.2.1, Counting Child Support, to estimate the date a child support payment is received by adding five days from the date a warrant was mailed or by adding two business days from the date an electronic transfer was initiated, excluding weekends and bank holidays. Therefore, when using Data Broker to verify child support, use the Receive Date as the estimated date the person receives a child support payment disbursed by the OAG.
- **Only payments disbursed to the person will be displayed to assist in reduction of calculation and payment errors.** All collections will be displayed in the Collections screen. Because all collections are potentially a deductible expense, only payments that were disbursed to the person will be displayed in the Disbursements screen to help reduce errors (e.g., payments given to HHSC as repayment services will not be displayed). If the OAG disbursed additional payments to an entity other than the person, disbursement information will be listed in the additional payments section of the report and will include the name of the entity that received the payment. This is displayed for informational purposes.

Note: If a person reports receiving child support via the Texas OAG and those payments are not being reflected on the Data Broker Portal, check the TXCSES Web portal to verify the payment(s). Infrequently, staff may also be unable to verify using the TXCSES Web portal. In this situation, pend the case for proof of the child support payment.

Example: A person is receiving child support payments for a dependent from an out-of-state order and the Texas OAG does not yet have the child support order but is receiving payments on behalf of the person.

- **Arrears payments are separated in the report to help ensure staff count them properly.** Enter arrears payments as income for the person to whom the payments are disbursed, not for the dependent.
- **Member addresses are displayed as a case clue to determine household composition and to aid in determining if an absent parent has moved back into the same home as the custodial party.** The Member Details section will display all members associated with the person for whom the report was requested. The report will display the person and all members associated with that OAG case.

Note: If an absent parent is making child support payments but moves back into the home of the caretaker and child, do not count the child support as income nor allow the child support as a deduction.

Related Policy

Child Support, A-1326.2
Medical Support Payments, A-1326.2.3
Reimbursements, A-1332
Child Support Deductions, A-1421

C-825.14.2 OAG Error Messages

Revision 19-4; Effective October 1, 2019

All Programs

Error messages may appear when a request is made and the OAG database information is unavailable. When the OAG information is requested and unavailable, a feature in the table of contents of the Standard Combined Report will display the following message:

“Request timed out. Please click here to retry again.”

By clicking on this link, staff can re-request the report without reentering all the person's information. Staff should continue to retry until the information becomes available.

C-825.15 SNAP Out-of-State IPV Disqualifications

Revision 19-4; Effective October 1, 2019

SNAP

This report lists Intentional Program Violation (IPV) disqualification information from other states applicable to the person for whom the report was requested. Follow policy in B-941, Disqualifying a Household Member with a Current SNAP Out-of-State IPV Disqualification, when this is reported.

C-825.16 Alien Status/Systematic Alien Verification for Entitlements (SAVE)

Revision 19-4; Effective October 1, 2019

All Programs

Data Broker provides a verification of alien status using SAVE.

Staff verify the immigration status of each non-citizen applying for benefits by accessing the:

- Data Broker Combined Report in TIERS; or
- Data Broker Portal.

When using TIERS, staff select Individual ID in the Individual Information LUW (only for people 16 years old or older), an Alien Status option appears at the top of the Data Broker Combined Report page with options:

- Alien Status — Sends a Request for Initial Verification to the Department of Homeland Security (DHS).
  - By clicking on the Alien Status option, the last name, first name and birthdate fields are prepopulated based on the information in TIERS Data Collection.
  - Enter the alien registration number per the U.S. Citizenship and Immigration Services (USCIS) document.
- Case History — Displays prior SAVE inquiry responses.

When using Data Broker Portal (All people including children under age 16 years old):

- Alien Status — Sends a Request for Initial Verification to the Department of Homeland Security (DHS).
  - By clicking on the SAVE option, staff will be required to enter the last name, first name and birthdate fields are prepopulated based on the information.
  - Enter the alien registration number per the U.S. Citizenship and Immigration Services (USCIS) document.
- Case History — Displays prior SAVE inquiry responses.

By clicking on the Verification SAVE Status option, the last name, first name and birthdate fields are prepopulated based on the information in TIERS Data Collection. Enter the alien registration number per the U.S. Citizenship and Immigration Services (USCIS) document. Staff should only access Data Broker reports for people 16 and older. Staff must continue to use the stand-alone SAVE Web-based system for people younger than 16.

Related Policy

Verifying Alien's USCIS Documents, A-355
Providing Verification of the Alien's Sponsor Income and Resources, A-316.1

C-825.16.1 Alien Status Historical Data

Revision 19-4; Effective October 1, 2019

All Programs

This feature searches alien status history for up to the last six months to determine if a previously submitted inquiry, with a valid document, is available. A new alien status inquiry will not display if any inquiry with a valid unexpired document has been completed within the last six months. A message will display along with the historical record when this occurs.

If the document on file is expired, a request to perform a new initial verification automatically occurs.

C-825.16.2 Alien Status Initial Verification

Revision 19-4; Effective October 1, 2019

All Programs

Choose the noncitizen's document type from a drop-down menu. The Document Type drop-down menu lists the most common types of documents used to verify alien status. If the document type is not listed, choose "Other." Depending on the type of document, staff must complete certain fields before submitting the request.

The card number from the I-551, Permanent Resident Card, that must be entered in SAVE is 13 alphanumeric digits and begins with three letters. I-551s issued between May 2004 and May 2010 have the card number on the front, and I-551s issued beginning in May 2010 have the card number on the back.

Note: To verify whether SAVE was completed, staff should use Data Broker Case History in the Data Broker Portal.

C-825.17 Inmate or Parolee Match

Revision 23-1; Effective Jan. 1, 2023

All Programs

The Inmate or Parolee Match displays prisoner information for people who are incarcerated.

The following identifying information is displayed, if applicable, for the incarcerated person:

- name;
- SSN;
- DOB;
- last known address;
- incarceration sentence date (first day of incarceration);
- earliest release date;
- prison unit;
- offense; and
- date of offense.

Prisoner match information displayed on the Data Broker Combined Report is considered a case clue, and must be addressed with the household before denying, reducing or terminating benefits. For applications, redeterminations and changes, attempt to contact the household by phone to inquire about the information found in the Data Broker Combined Report.

If the household agrees that the person is incarcerated or the person is not living with the household, remove the person from the case and retest eligibility.

Send Form H1020, Request for Information or Action, to request verification of household composition if:

- the household disagrees with the inmate or parolee match and states that the person lives in the home; or
- phone contact cannot be made.

If the household does not respond to the Form H1020 and the household is a:

- SNAP streamlined reporting (SR) household, remove the incarcerated person from the household.
- SNAP non-SR, TANF, or Medicaid household, deny the household for failure to provide.

Document the following information in case comments:

- the household's response about if they agreed or disagreed with the incarceration information in Data Broker;
- when a household member is excluded because of incarceration information in Data Broker;
- any attempts made to verify and explain how questionable information was cleared; and
- when a fraud referral is sent to OIG.

Related Policy

Verification Sources, A-251
Streamlined Reporting Households, A-2350
When to File an Overpayment Referral, B-720
Questionable Information, C-920
Documentation, C-940

C-825.18 Texas Lottery Commission

Revision 21-1; Effective January 1, 2021

All Programs

This report contains Texas Lottery Commission verification of winnings and is displayed on the data broker combined report. The report contains the following information:

- winner's full name, date of birth and Social Security number;
- paid date;
- gross, net and taxes withheld amounts;
- check ID, claim number and date claim created;
- debt offset (is the same as recoupment):
  - reason for the offset;
  - the agency name the offset is for;
  - withholding amount;
  - withholding number;
  - withholding sequence number; and
  - check ID and agency ID; and
- void date.
  - Only provided if the Texas Lottery Commission voids a check.
  - The winnings must not be counted as income.

Related Policy

Texas Lottery Commission, A-1326.28

C-826 Entry Instructions

Revision 12-4; Effective October 1, 2012

C-826.1 Requesting Data Broker Reports in the Stand-alone System

Revision 19-4; Effective October 1, 2019

Use the Data Broker Portal to pull specific data element searches, such as TWC, OAG, etc. Staff can also use the Data Broker Portal if TIERS is experiencing technical issues.

All Programs

DL Number: Enter the TDL number or Texas ID card number. This is not a mandatory entry, but when staff enter this number and click the Lookup button, the system automatically pulls data for all fields except SSN and Case Number. If DPS data is incorrect or obsolete, enter the correct data over the incorrect data.

Inquire On: Click on the appropriate description for the person on whom you are making the inquiry.

- Applicant — New applicants or household additions.
- Recipient — Currently active recipients.
- None of the Above — Anyone who is not an applicant or recipient.

SSN: Enter the SSN of the person for whom you need Data Broker information. Do not enter an incorrect or false SSN. If an incorrect SSN is entered, an erroneous file may be created or information for the wrong person may be pulled.

Case Number: Enter the TIERS application/case number. Never enter a false TIERS application/case number or one belonging to another person.

Enter information in the remaining fields marked with an asterisk when the Texas ID or TDL number is unknown. These fields are self-explanatory.

C-826.2 Requesting Data Broker Reports in TIERS

Revision 19-4; Effective October 1, 2019

Staff must request and view the Data Broker Combined Report for applicable household members to accurately determine eligibility and clear any discrepancies. Failure to view this report may result in eligibility errors that can lead to quality control errors.

In the TIERS Regular or Customized Redetermination driver flow, submit a Data Broker request for each individual household member 16 and older, including members without an SSN.

In the Redetermination Summary logical unit of work, each page has a DB icon



- Click the DB icon



- at the top of the page to access the Data Broker window.
- The Data Broker Combined Report link will display.
- Click on the Data Broker Report link to view the Data Broker Combined Report for the person.

Follow the same process for each additional household member for whom a Data Broker Combined Report is needed. The Data Broker Report Link expires after 15 minutes if not clicked.

Data Broker in TIERS cannot do interactive searches on specific data; it only produces the Combined Report. For example, if staff only needs OAG information, staff go to the Data Broker Portal instead.

Requesting a Data Broker Combined Report with Credit Information

A credit report may be requested after a Data Broker report has been displayed. At the bottom of each Data Broker report is a section that allows a credit report to be requested on the person for whom the Data Broker report was run. There is a message displayed that states, “Click here to request and view a credit report.” Clicking on the link is a request for a credit report.

Related Policy

Data Broker, C-820
Permissible Purpose, C-824

C-827 Data Broker Combined Report Sources With Credit Report

Revision 19-4; Effective October 1, 2019

All Programs

The credit information provided in Data Broker Combined Report with credit information is received from Experian. It also includes all the sources found in C-825, Combined Data Broker Report Sources.

Related Policy

Data Broker, C-820
Permissible Purpose, C-824

C-827.1 Credit Report

Revision 19-4; Effective October 1, 2019

All Programs

Information provided on this screen is provided to the credit reporting agencies by creditors. Use the information as a case clue only when determining:

- household management;
- vehicle ownership;
- employment; and
- other potential causes of case errors.

Verify credit report information before taking any action on an EDG.

C-827.1.1 Reserved For Future Use

Revision 19-4; Effective October 1, 2019

C-827.1.2 Reserved For Future Use

Revision 19-4; Effective October 1, 2019

C-827.1.3 Reserved For Future Use

Revision 19-4; Effective October 1, 2019

C-827.1.4 Credit Summary

Revision 13-3; Effective July 1, 2013

All Programs

This screen is a record of information creditors provide to the credit reporting agencies. Use the information as a case clue in determining:

- household cash flow,
- vehicle ownership,
- employment, and
- other potential causes of case errors.

The information is generally accurate; however, it cannot be considered verification for any action taken by HHSC. The advisor must verify credit report information before taking any action on an EDG.

C-827.2 Active and Inactive Accounts

Revision 19-4; Effective October 1, 2019

All Programs

This report contains detailed information from creditors which includes corresponding payment records.

This information should be used as a case clue for the household's management. For example, if all credit cards are paid yet the household's management is negative, staff should ask how the household is able to pay all bills with reported income.

C-827.3 Lender Information

Revision 19-4; Effective October 1, 2019

All Programs

This report provides the name, address and phone number of the creditor.

C-827.4 Client Income

Revision 19-4; Effective October 1, 2019

All Programs

This report includes information the person reported to lenders regarding their income. This information is not available on every report and is based only on the person's statement.

Compare employers and income listed to information received during the interview or from the application. Explore any other income or discrepancies reported by the person to lenders.

C-827.5 Inquiries for New Credit

Revision 19-4; Effective October 1, 2019

All Programs

This report lists the names and dates of credit inquiries for the person. Each time a credit report is requested, the name of the requestor and the date of the request is added to the person's credit report.

An inquiry may indicate the need to further explore the person's income and resources. For example, inquiries from auto dealers or auto lending institutions are case clues to a possible vehicle purchase.

C-828 Providing Copies of Data Broker Reports

Revision 19-4; Effective October 1, 2019

All Programs

Do not print a Data Broker report unless a person:

- Requests a copy of the Data Broker (DB) report, staff must provide a copy of the DB report.
- Requests a fair hearing and staff used a Data Broker report (including a credit report) to determine eligibility, mail a copy of the Data Broker report, including the credit information, to the hearing officer with the other case information.
- Questions the credit report information, explain that eligibility was based on several sources, including a credit report obtained from the consumer reporting agency.

For most inquiries, historical DB information is retained for five years from the initial inquiry date. Staff can retrieve and view previously pulled Data Broker inquiries through the Data Broker Portal.

A person has the right under the Fair Credit Reporting Act (FCRA) to obtain a free copy of the person's credit report within 60 days from the notice of adverse action. To obtain a free copy, the person can contact Experian at:

701 Experian Parkway
P.O. Box 4500
Allen, TX 75013
888-397-3742
www.experian.com

Related Policy

Permissible Purpose, C-824

C-829 Case Actions

Revision 19-4; Effective October 1, 2019

All Programs

When information on any report and the person's statement are discrepant, offer the person an opportunity to verify the information.

When staff discover questionable information, treat it as any other questionable information. Provide the individual Form H1020, Request for Information or Action, and pend for verification.

When staff request Data Broker information during a SNAP certification period and the report reveals information regarding anything other than vehicles, follow procedures in B-125.1, Due Dates.

When HHSC takes adverse action on an EDG based on information gained either directly or indirectly through the use of a credit report, the FCRA requires HHSC to notify the person. Staff must indicate in TIERS the action taken was based on credit report information and the TF0001 notice contains specific information about client rights mandated by the FCRA.

Related Policy

Permissible Purpose, C-824
Notice to Applicants, A-2310

C-830, Child Support Systems

Body

C—831 Grant in Jeopardy Process

Revision 15-4; Effective October 1, 2015

TANF

The OAG sends the TANF recipient child support collection interface after the close of business on the last day of each month. HHSC uses the interface to determine if child support collections exceed the TANF grant plus the disregard and processes grant in jeopardy.

The TANF recipient child support collection interface includes the:

- TANF case information;
- amount of collections from each absent parent; and
- amount of excess payments.

HHSC automation staff:

- compare the OAG collection information to the current TIERS information;
- send a notice of excess payment to the advisor, if applicable;
- determine if any member of the certified group was certified for TP 01 or TP 61 in at least three of the last six months; and
- determine if the collection still exceeds the TANF grant plus the disregard.

If the collection amount exceeds the TANF grant plus the disregard, the system:

- places the EDG on hold, pending denial;
- produces a notice reflecting automated action to the advisor and individual; and
- denies the EDG if the EDG is still on hold at cutoff in the hold effective month.

Examples

November – The OAG receives child support collections on TANF EDGs. At the end of the month, the OAG sends the collection information to HHSC. HHSC determines:

- whether the collection causes grant in jeopardy; and
- if there is an excess payment.

December – HHSC receives the collection information the first week of the month. TIERS compares the collection to the grant plus disregard. If it exceeds the grant plus disregard, TIERS:

- places the TANF EDG on hold effective January 1;
- produces a notice to the advisor;
- produces a notice to the individual; and
- sends the updated tape to the OAG at cutoff.

The OAG repeats the process shown in November for any December child support collections received.

January – The TANF EDG is on hold. In the first week of the month, the OAG sends:

- the disregard to the individual (from the December child support collection);
- any excess payment to the individual (from the December child support collection); and
- any January child support collections (as they are received) to the individual.

At cutoff, TIERS denies the case.

February – The OAG sends any collected child support to the individual.

C—832 Office of the Attorney General (OAG) Inquiry

Revision 05-5; Effective October 1, 2005

All Programs

The Texas Child Support Enforcement System (TXCSES) is the OAG computer inquiry system. Staff access TXCSES for verification of child support information. In order to access TXCSES, staff must have an OAG user identification number. Obtain a user ID by:

- completing OAG security Form 08.010, Office of the Attorney General Child Support Division Information Access Statement of Responsibility, and HHSC security Form 4743, Request for Applications and System Access; and
- mailing both forms to the Regional Security Officer (or designee), who forwards them to the state office security officer. The state office security officer coordinates assignment with the OAG.

Staff must use their security IDs at least every 30 days or the ID becomes dormant and must be reset through the security system.

This section contains information about entering and exiting the system and an explanation of the screens. Refer to the user guide for detailed information.

C—832.1 Accessing Texas Child Support Enforcement System (TXCSES)

Revision 05-5; Effective October 1, 2005

All Programs

Download the system from www.tx.net/download/oag. Use the following steps to access the system.

1. Click on the designated icon or click on the Start button and then click Qws3270.Exe.
2. At the ENTER LOGON prompt (Texas map screen), type TXAGCNTY, press Enter.
3. On the same screen, click on the Reset button, and then click on the Clear button. These buttons are at the bottom of the application window.
4. The OAG Child Support Enforcement screen appears.
5. Follow the standard logon procedures:
    1. In the Application ID field, type "CSES."
    2. Tab to the User ID field and type in your User ID.
    3. Tab to the Password field. The first time you sign on, type your temporary password assigned on Form 4743.
    4. Tab to the New Password field and type in a new password. The new password must:
        - be exactly eight characters in length;
        - be a combination of alpha, numeric and allowable special characters(allowable characters are @, # and $);
        - contain at least one special character that must not be located in the first or last positions;
        - contain only one set of repeating characters;
        - be changed every 32 days;
        - not be shared, written down or posted; and
        - not be reused for periods of up to one year.

        When you press Enter, the system will ask you to retype your new password. The next time you sign on you will use your new password.
    5. The Child Support Enforcement Menu appears. To access a screen, you may type the number corresponding to a screen shown on the menu or you may go directly to the screen by typing the four-letter screen ID in the Command line. Press Enter.

C—832.2 TXCSES Menu Screens

Revision 08-4; Effective October 1, 2008

All Programs

The following is a partial list of available inquiry screens in the Texas Child Support Enforcement System (TXCSES):

- **Member Search Selection Screen (MSCH)** — Use to search for a member with a minimum amount of identifying information.
- **Member to Cases Inquiry (MCAS)** — Identifies all cases a member is associated with and other members related to these cases.
- **Case Information (CINF)** — Displays basic information about a case.
- **Case Profile (CPRF)** — Displays high level information on a case, such as case type, status of case, number of dependents, grant amount, custodial parent (CP) and non custodial parent (NCP) name and their member ID number and current addresses, NCP earnings, and whether health insurance is available through the employer.
- **Grant History Screen (GRNT)** — Displays the monthly detail of the grant history and Prior Months Unrecovered Assistance (PMUA) by HHSC Case No..
- **Monthly Receipt Summary (MRSM)** — Displays the distribution of the collections for a CP on a monthly basis.
- **Warrant Status History (WHIS)** — Displays the disbursement status for a specific warrant or electronic fund transfer (EFT) identifying a direct deposit. The date the warrant was disbursed, issued, mailed, or cancelled. The dollar amount of the warrant and warrant number. The CP's current address and the address where the warrant was mailed.
- **Child Support Office Directory (CSOD)** — Provides general information about a child support office.
- **Child Support Staff Directory (CSSD)** — Use to search for a specific employee or group of employees. Also, use to identify the name, current address, and telephone number of the child support officer who initiated a sanction request.

C—832.3 Exiting TXCSES

Revision 04-7; Effective October 1, 2004

All Programs

To exit TXCSES:

- press F3 when the main menu (CSEM) displays;
- type exit or end in the Command line; or
- click on the windows X or close while in any of the screens and then click on Exit, located on the top bar menu.

C—833 TXCSES Web Child Support Portal Inquiry

Revision 08-4; Effective October 1, 2008

All Programs

The TXCSES Web is an Internet-based application developed by the OAG. The TXCSES Web is a comprehensive verification source that allows users to view child support collection, distribution and support obligation records.

TXCSES Web replaces the TXCSES OAG computer inquiry system as the primary verification source for child support payment information.

C—833.1 Requesting Access to TXCSES Web

Revision 08-4; Effective October 1, 2008

All Programs

Advisors with access to the TXCSES OAG computer inquiry system will use a USER identification (ID) and password to access TXCSES Web. New users must obtain a USER ID by completing:

- the OAG security Form 08.010, Office of Attorney General Child Support Division Information Access Statement of Responsibility; and
- the HHSC security Form 4743, Request for Applications and System Access.

Mail both forms to the Regional Security Officer (or designee), who forwards the forms to the state office security officer. The state office security officer coordinates assignment with the OAG.

C—833.2 Logging On to TXCSES Web

Revision 08-4; Effective October 1, 2008

All Programs

Advisors must have an active USER identification (ID) to access the TXCSES Web. The USER ID and password for TXCSES Web is the same logon as the one used to access the TXCSES OAG computer inquiry system. To log on to TXCSES Web:

1. Open the link to the TXCSES Web application in the browser (https://portal.cs.oag.state.tx.us/wps/portal).
2. Type your USER ID in the User ID field.
3. Type your password and click **Login**.
4. Read the Statement of Responsibility and click **I Agree**.
5. Read the Account Policy and click **I Agree**.

6. Click **TXCSES Web** located at the top under the header **Child Support Online**. This will bring up the **Main Search Income Verification Screen**.

C—833.3 Procedures for Obtaining Payment Information

Revision 08-4; Effective October 1, 2008

All Programs

The Texas Child Support Enforcement System (TXCSES) **Web Main Search Income Verification Screen** includes four member search options:

- Last Name and/or First Name
- DOB, MMDDYYYY
- SSN, 123456789
- Member ID (OAG Member ID)

Note: Advisors should use an SSN for inquiry when possible for a more accurate method of locating an applicant's information.

From the Search Results section, click on the case ID number with an "active status" to retrieve the child support payment information such as collections, distributions and support order obligations.

Note: By clicking on the + icon on the **Disbursement Summary Details** column, the advisor can view the payment type such as warrant, direct deposit/electronic transfer and Texas debit card. See A-1326.2.1, Counting Child Support, for assistance in determining when to consider the payment type available to the custodial parent.

C—833.4 Logging Off of TXCSES Web

Revision 08-4; Effective October 1, 2008

All Programs

Click Logout to exit the Texas Child Support Enforcement System (TXCSES) Web application. Users are automatically logged off the application after 30 minutes of inactivity. Three unsuccessful logon attempts or 30 days of inactivity in either TXCSES or TXCSES Web suspends the USER identification (ID). Contact the regional security officer to reset the password if this occurs.

It is important to keep the user name active by logging on periodically. If staff do not logon to TXCSES or TXCSES Web within 90 days of the last logon, the user name is deleted.

C-840, DataMart

Body

Revision 26-1; Effective Jan. 1, 2026

All Programs

DataMart provides a series of online reports, accessed through the state portal. The reports are used as monitoring tools for various case action activities within Texas Works.

C–841 DataMart Reports

Revision 26-1; Effective Jan. 1, 2026

Number	The Report
DF-001a	**Felony Drug Conviction (FDC) Disqualification for SNAP** Provides a monthly count of people previously disqualified for an FDC that occurred on or after Aug. 22, 1996, who are now receiving SNAP benefits on an approved SNAP EDG.
DF-001b	**EDGs Denied for Parole or Community Supervision Compliance Verification** Provides data on SNAP EDGs denied for failure to provide verification of compliance with parole or community supervision.
DF-001c	**SNAP FDC Disqualifications** Provides data on the number of people with a two-year or permanent SNAP disqualification related to FDC.
DF-012	**Daily Failure to Provide All Missing Information** Provides data on SNAP cases pended for income or resources and denied by the system mass update. This includes cases that excepted from the system process and cases requiring action without an associated task.
DG-001	**Reviews and Recertifications Due by Office** Allows managers and appropriate field staff to identify TANF, Texas Works (TW) Medicaid, CHIP and SNAP Redeterminations due in a month specified by the user.
DG-002	**Pending Applications** Allows managers and appropriate field staff to identify pending TANF, SNAP, TW Medicaid, CHIP, CHIP perinatal and Healthy Texas Women (HTW) applications daily.
DG- 003	**Work In Progress (WIP)** Allows managers and appropriate field staff to identify open TANF, SNAP, TW Medicaid, CHIP, CHIP perinatal and HTW actions daily.
DG-004R	**Delinquency Analysis Data Report** Provides consolidated detailed data to aid in the analysis of causal factors contributing to each delinquency.
DG- 006	**Task List Manager (TLM) Task Aging by Past Due Date** Allows managers and appropriate field staff to identify all the tasks not closed by the TLM task due date.
DG-007	**Appointment No Show** Gathers all the details for an appointment with a No Show (NS) status to ensure TLM No Show task actions are completed on time.
DG-009	**Tickets and Service Request Status Report** Provides a consolidated source for viewing all open Remedy and Project and Portfolio Management Center (PPM) tickets or recently closed PPM tickets.
DG-010	**Disposition Timeliness Report** Helps management efficiently monitor the timeliness percentage, total dispositions for all applications and redeterminations, timely and untimely dispositions and the number of disposing employees for TANF, SNAP, TW Medicaid, CHIP, CHIP perinatal, and Medicaid for the Elderly and People with Disabilities (MEPD) programs. This report displays the timeliness based on the disposition date. **Note:** This report provides timeliness for redeterminations disposed timely or untimely. Types of Assistance (TOAs) with a passive renewal are included if a recertification package is received and processed.
DG-011	**Review Timeliness Report** Helps managers efficiently monitor the number of delinquent reviews, the age of the delinquent reviews and the percentage of the total caseload that is delinquent for the following three types of assistance in TIERS: • MA - Parent and Caretaker Relatives • TANF Basic • TANF State Program **Note:** This report provides information on past due redeterminations that were not processed or disposed. Timeliness for other programs is monitored through other reporting mechanisms. TOAs with a passive renewal are included on this report.
DG-012	**Pending Applications and Redeterminations over 60 Days** Helps management identify and monitor applications and redeterminations pending over 60 days for SNAP, TW Medicaid, CHIP, CHIP perinatal, TANF, and MEPD daily, and identify the current employee assigned with pending applications and redeterminations.
DG-014	**Merge/Separate (M/S) WIP Report** Help management and data integrity staff identify and monitor pending M/S TLM request tasks daily.
DG-015	**M/S Timeliness Report** Assist management to efficiently monitor the number of completed M/S TLM requests, and the number and percentage of timely completed M/S TLM requests.
DG-016	**M/S Daily Potential Duplicate Report** Provides Data Integrity staff a daily list of potential TIERS duplicate individual IDs created and/or updated on any given day and an individual summary and potential match detailed level reports.

Number	The Report
DG-017	**Office of Eligibility Services (OES) Community Based Organization (CBO) Data Report** Helps with statistics for federal reporting on the community partner project. The report provides the number of CBO applications and redeterminations: • submitted; • pending; • disposed; and • percentage of total EDGs processed timely.
DG-021	**Request for Review Report** Allows managers and appropriate field staff to view the CHIP and CHIP perinatal request for review report by region, status, manager and employees. The report captures the number of requests for review pending, completed, and requests for retro coverage.
DG-022	**Automated Electronic Reminders** Provides the status of the total number of current subscriptions to electronic reminders at the end of each month. Provides the number of electronic reminders sent to people for each reminder type.
DG-038	**EDG-Level Processing for Medicaid Renewals** Provides EDG-level information for EDGs completed through the automated Medicaid Renewal Process.
DG-039	**ACA Periodic Income Check Report** Provides EDG-level information for EDGs eligible for the periodic income check.
DM-002	**Qualified Hospital and Qualified Entity Presumptive Eligibility Report** Provides Community Access Services (CAS) staff with statistical data on Presumptive Eligibility (PE) about the number of approved and denied PE determinations. It also provides the number of Medicaid-assisted approved or denied applications. Allows CAS staff to determine if an error should be counted toward a qualified hospital based on the accuracy and timely submission of a PE determination.
DM-005	**Reasonable Opportunity Report** Provides the total number of people receiving a period of reasonable opportunity to provide verification of alien status or citizenship and the number of times a person was given a period of reasonable opportunity to provide verification of alien status or citizenship.
DM-007	**HB 839 Reinstatement of Medicaid** Provides Centralized Benefit Services (CBS) staff a listing of children whose TP 44 eligibility was suspended on notification from Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) of placement in a juvenile facility, or reinstated on notification from TJJD or JPD of release from a juvenile facility.
DM-008	**FFCC Ongoing Monitoring Reports** Allows management and appropriate staff to track and review various data about people who may be eligible for or are currently receiving Former Foster Care Children's (FFCC) Medicaid (TA 82). There are six sub-reports: • People Certified for Non-FFCC Program, Lower than FFCC Hierarchy ◦ Provides a list of people who are 18 through 25, received Foster Care - Federal Match - No Cash (TP 93) or Foster Care - Federal Match - With Cash (TP 94) on their 18th birthday or later, and are certified for a Medicaid program below TA 82 in the Medicaid hierarchy. • People Certified for Non-FFCC Program, Higher than FFCC in Hierarchy ◦ Provides a list of people who are 18 through 25, received TP 93 or TP 94 on their 18th birthday or later, and are certified for a Medicaid program above TA 82 in the Medicaid hierarchy. • People Terminated Ongoing Medicaid or Denied at Application ◦ Provides a list of people who are 18 through 25, received TP 93 or TP 94 on their 18th birthday or later, applied for non-TA 82 coverage and were denied, or who were on a non-TA 82 Medicaid program and were denied coverage at application or denied on-going Medicaid coverage. • Active FFCC Individuals Denied ◦ Provides a list of people who received TA 82 and were denied TA 82 coverage in the report month. • Active FFCC Individuals ◦ Provides a list of all active people on TA 82. • TP 93 and TP 94 Denied ◦ Provides a list of people 18 through 20 who were receiving TP 93 or TP 94 in the report month but are not receiving Medicaid in the month following the report month.
DM-011	**TP40 Transition Report** Identifies enrollment patterns and transitions between TP 40 and other programs. The DM-011 TP 40 Transition Report also allows staff to review cases when women enrolled in TP 40 do not transition to other coverage and when Alert 824s are not processed timely.
DM-012	**HB 337 County Jail Reporting** Identifies people suspended, terminated, or reinstated due to county jail confinement or release.

C-850, One-Time Grandparent Payment System

Body

Revision 22-3; Effective July 1, 2022

TANF

The Grandparent Payment System (GPS) archives historical Grandparent Payments issued before EDGs converted into TIERS.

C—851 Sign-On Screen

Revision 10-4; Effective October 1, 2010

TANF

Users request access to the GPS application by:

- registering on the Health and Human Services (HHS) Enterprise Portal, then
- requesting access to the GPS application in the HHS Enterprise Portal.

Users must register and have access to the HHS Enterprise Portal before access to the GPS application is requested and granted.

First-time portal users must register on the HHS Enterprise Portal and follow prompts to receive log-in credentials.

Returning portal users do not have to register again. Every 90 days, the user's HHS Enterprise Portal password expires and a prompt will appear to change it.

C—851.1 GPS Application Access

Revision 10-4; Effective October 1, 2010

Once in the HHS Enterprise Portal, users must request access to the GPS application by clicking on the Request Application Access tab at the top of the page. Select GPS Account from dropdown list of applications. A request is sent to the user's supervisor for approval and is automatically forwarded to the regional security officer for final approval. An email notification is sent to the user when the request is approved.

After permission to access the GPS application is granted, a tab labeled GPS appears on the HHS Enterprise Portal home page when the user is logged in. A message indicating Sign-On Successful appears on the GPS home page after the user clicks on the GPS tab.

C—852 GPS Inquiry Screen

Revision 22-3; Effective July 1, 2022

TANF

This screen allows a search by case or by person. To search by case, enter the case number and click on Search by Case. To search by person, enter the person’s client number, name or SSN and click on Search by Client. When inquiring by name, enter the last name. The first name is optional.

C—852.1 Case Inquiry

Revision 22-3; Effective July 1, 2022

TANF

This screen includes the following case information:

- case number;
- case name (last, first);
- address;
- benefit effective date;
- data entry date;
- advisor name;

- advisor BJN; and
- advisor phone number.

There are three other options on the screen: View Case Members, View Case Warrants and Return to Inquiry Results. View Case Members lists household members included in the One-Time Grandparent certified group. View Case Warrants lists warrants and the date issued, including the:

- primary client number (PCN);
- SSN;
- employee number;
- entry date;
- pay date;
- issued by comptroller date;
- warrant number;
- amount; and
- status.

C—852.2 Client Inquiry

Revision 22-3; Effective July 1, 2022

TANF

When searching by client, enter the person's client number, name or SSN. The Client Inquiry screen displays the person's:

- primary client number (PCN);
- name;
- DOB;
- SSN;
- sex; and
- case number.

Click on the case number to get the Case Inquiry screen.

C-860, Birth Verification System

Body

Revision 12-3; Effective July 1, 2012

All Programs

The Birth Verification System (BVS) is a system developed and maintained by the Department of State Health Services (DSHS). The BVS database includes birth records of people who were born in Texas.

Advisors access BVS as a source to verify age, relationship and citizenship. Perform a separate request for each individual.

C—861 Accessing BVS in TIERS

Revision 12-3; Effective July 1, 2012

All Programs

BVS inquiry can only be performed when the TIERS case is in read/write mode. From the left navigation bar select Individual from Data Collections to access birth verification information. This displays the Individual Household page, which lists all household members. Click the Edit icon for the appropriate individual. This displays the Individual Information page.

A BVS icon appears on the Individual Information page, near the page title. The icon consists of a circle with the letters BV in it. Click the icon to display the page. TIERS displays the Birth Verification – Details page, displaying the initial demographic information for the individual, individual's first, middle and last name, gender, and date of birth. Select the Birth County (if available) and enter Mother's full Maiden Name (if available), then click the Submit button.

TIERS sends an online request to BVS. BVS conducts an online real-time verification of birth information and displays the information on the details page.

Note: TIERS does not display historical birth verification information. If staff make another BVS request for an individual, TIERS generates a new request to the BVS system.

C—861.1 BVS Field Entries and Descriptions

Revision 13-1; Effective January 1, 2013

All Programs

TIERS displays the Birth Verification – Details page, displaying the initial demographic information for the individual:

- child's last, first and middle name,
- date of birth, and
- gender.

Birth County — Select the birth county from the drop-down menu. **Note:** Although not a required field, entering the county code shortens the search.

Mother's Maiden Name (optional field) — Enter mother's full maiden name if available; this is an optional field. Do not enter a single letter, numerical value, spaces or special characters.

Once the BVS request is submitted, the request is transmitted to DSHS. DSHS returns the following response information when there is response from DSHS indicates a positive match:

- mother's maiden name,
- certificate no.,
- father's name, and
- birth county.

Status — This field displays one of the following responses to the request submitted.

Y = Match Found

M = Multiple Records Exist

N = No Match Found

F = Fraudulent Record

D = Individual is Deceased

S = Birth File Read Error

T = Invalid Date of Birth

X = Unknown Error. Call Help Desk

When a match is not received, staff must review entries for accuracy and resubmit the BVS request.

Message — The following exception messages are displayed when a response is not received and the request and response have caused some type of exception. This means there is an error with the system or the data. Call the HHSC Help Desk if problems persist at 512-438-4720.

Message Codes	Descriptions
20745	Unable to send MQ message. Please try again later and contact Help Desk if problem persists.
20732	Invalid data received in the response. Please try again later and contact Help Desk if problem persists.
20731	Response timed out. Please try again later and contact Help Desk if problem persists.
20730	An unexpected error has occurred. Please try again later and contact Help Desk if problem persists.

C-870, Other Systems

Body

C—871 Wire Third-Party Query (WTPY)

Revision 15-4; Effective October 1, 2015

All Programs

WTPY is an SSA automated system that verifies Social Security benefits, SSI, 40 quarters information and citizenship verification for Medicaid. WTPY is a Windows application. Staff obtain information by using the individual's name, SSN or Social Security claim number (SSCN) (not applicable for Medicaid citizenship verification), and DOB. If staff transmit the request by 2:30 p.m., the response is received the following business day. If staff transmit the request after 2:30 p.m., the response is delayed one additional day.

When an inquiry match occurs, the response provides all available benefit information. If the individual has entitlement under more than one SSCN, those SSCNs and benefits are identified. Staff may have to submit separate inquiries to obtain data related to those claims.

The WTPY system provides the following types of responses:

- **Standard Response:** individual name, DOB, verified SSN, and error messages regarding any discrepancies between inquiry and response match.
- **Title II (Retirement, Survivors and Disability Insurance [RSDI]):** individual demographics, enrollment in Medicare Part A and/or Part B, supplementary medical income benefits (SMIB) premium deduction, benefit amounts and dates, unearned income, disability onset dates, etc.
- **Title XVI (SSI):** individual demographics, Medicaid, SSI payment history, benefit amount, payment status code, and resource and earned income leads, etc.
- **40 Quarters:** Use to verify quarters for legal permanent residents, their spouse or parents. Response provides employment history, coverage of quarters, and the type of income the individual has received during that period (wages, agricultural, self-employment, etc.). Note: Response time for this data is within two days of transmittal.
- **Medicaid Citizenship Verification:** Use to verify SSN and citizenship for Medicaid applicants. Response codes of A or C indicate citizenship is verified. However, response code C means there is an indication of death. If this response code is received, treat this as a report of change using policy in B-600, Changes. Response codes of B or D or any other error code indicate citizenship is not verified. If one of these responses is received, follow the steps outlined in A-351.2, Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship.

C—872 Accessing Wire Third-Party Query (WTPY)

Revision 22-4; Effective Oct. 1, 2022

All Programs

Request access to WTPY using the HHS Enterprise Portal.

To access the system:

1. Double click the LONG-TERM CARE or WTPY icon or hhsportal.hhs.state.tx.us. The sign-on screen appears.
2. Enter employee's username and password.
3. Click on Logon or press Enter.
4. Click on Logout to close the WTPY system.

You must change your password every 90 days, or the system automatically revokes your access.

The *WTPY Reference Guide* provides details about menus, screen and data field references for all SSA response screens.

C—873 Texas Works Automated Systems Problem Reporting Guide

Revision 13-4; Effective October 1, 2013

All Programs

Texas Works Automated Systems Problem Reporting Guide - IEE/TIERS Technical Help Desk

- 1-800-214-4175 (Option 1)
- 8 am to 8 pm CST, Monday - Friday

For all TIERS or State Portal-related issues, call 1-800-214-4175 (Option 1)

For Problems With	Examples of problems the Help Desk handles
Security	Security, permissions or lockout problems for TIERS and State Portal only
Management Reports	TIERS and DataMart report problems Prepare to have the following information available: • State Portal User ID • Office or cubicle number (desk location) • Supervisor's name and phone number • Full computer name • Report number trying to view • Screens within the report attempting to view • Exact steps attempting to make • TIERS Case number (if applicable)
TIERS	• Application problems • System availability • Errors messages and functionality issues Prepare to have the following information available: • Contact name • Contact employee ID • Contact phone number • Contact email address • Last time access TIERS • Office/region • ART name • ART phone number • ART email address • Alt contact/supervisor name • Alt contact/supervisor phone number • Alt contact/supervisor email address • Case name • Case number • Individual number (if problem is specific to an individual) • EDG number and EDG name (if specific to an EDG) • Current case mode • Programs • URL of site • Number of people having this issue • Description of the error or issue • Be prepared to email screen shot when reporting an error **Note:** Individuals call 2-1-1 for issues with the Self-Service Portal.
Caller Contact Information	• Contact information (phone number, email address, office/cubicle number, street address) • Supervisor's contact information (full name, phone number, email address)
Error	• Exact error message and sequence of events leading to problem • Detailed description of the problem • Application type (application, redetermination) • Specific screen in TIERS/State Portal the error is or was on prior to the error message **Note:** Make a screen shot of error message and be prepared to email screen shot as a Microsoft Word attachment.
Impact	Identify impact as: • Affects multiple advisors, programs or cases. • Prevents staff from continuing their work. • Single person impacted.

For Problems With	Examples of problems the Help Desk handles
	Note: Have specific examples of others impacted.

Note: Contact your local help desk to report non-TIERS and non-State Portal related issues

Problem Reporting Via Email IEE_Help@HHSC.state.tx.us

For Problems With	Examples of problems the Help Desk handles
Security	Report all security or password-related issues by calling the IEE/TIERS Technical Help Desk.
Management Reports	TIERS and DataMart report problems Prepare the same information as required above. **Note:** Make a screen shot of the error message and attach it to the email as a Microsoft Word document.
TIERS	• Application problems • System availability • Errors messages and functionality issues Make a screen shot of the error message and attach it to an email as a Microsoft Word document. **Note:** It is highly recommended to report TIERS-related issues using the TIERS Application Support Email Ticket Submission at http://hhscx.hhsc.state.tx.us/tech/CS/TIERS%20Template%202013%20(revised%202013-02-13-1910).pdf in a secure email.
State Portal	• Application problems • System availability • Error messages and functionality issues Provide the same information as required above. **Note:** Make a screen shot of the error message and attach it to an email as a Microsoft Word document.
Self-Service Portal	• Application problems • System availability • Error messages and functionality issues Provide the same information as required above. **Notes:** • Make a screen shot of the error message and attach it to an email as a Microsoft Word document. • Individuals call 2-1-1 for issues with the Self-Service Portal.
Error	When describing your error or issue: • Explain the exact error message and sequence of events relating to the problem • Include a detailed description of the problem • Include the Application type (application, redetermination) • Identify the specific screen in Self-Service Portal/State Portal the error is on or was on prior to the error message
Impact	Identify impact as: • Affects multiple advisors, programs or cases • Prevents staff from continuing their work • Single person impacted

For Problems With	Examples of problems the Help Desk handles

Note: Have specific examples of others impacted.

C-900, Verification and Documentation

C-910, Required Verification

Body

C—911 Required Verification for TANF

Revision 19-3; Effective July 1, 2019

TANF

Mandatory Verifications	At Application	When a Change Occurs	At Redetermination
Household Composition – Out of State Disqualifications for Felony Drug Convictions	All household members applying	Any new household members applying	Any new household members applying
Citizenship	All household members applying who claim to be U.S citizens	Any new household members applying who claim to be U.S. citizens	Any new household members applying who claim to be U.S. citizens
Alien Status	Household members identified as aliens	New members identified as aliens	• New members identified as aliens • When the U.S. Citizenship and Immigration Services (USCIS) document has expired.
Social Security Number (SSN)	Household members who cannot provide an SSN, verify they applied for an SSN	New members who cannot provide an SSN, verify they applied for an SSN	Household members who cannot provide an SSN, verify they applied for an SSN
Age/Relationship	All children applying	New children applying	New children applying
Identity	Person being interviewed	If not previously verified	If not previously verified
Residence	• Physical address • Intent to remain in Texas • New Texas residents applying, verify the last month a member received benefits in another state	New Texas resident applying, verify the last month any new member received benefits in another state	• Physical address • Intent to remain in Texas • New Texas residents applying, verify the last month any new member received benefits in another state
Domicile	• All children applying • Unmarried minor parents applying • Temporary absence for all household members applying	• New children applying • New unmarried minor parents applying • If questionable, all certified children • Temporary absence for any new household members applying	• All certified children • Certified unmarried minor parents • Temporary absence for all certified household members
Child Support – Good Cause Claims	Any good cause claim	Good cause claim for new children applying	Good cause claim for new children applying

Mandatory Verifications	At Application	When a Change Occurs	At Redetermination
Resources	• Checking/savings/ retirement/ education account(s) • Other – if within $300 of the maximum	• New checking/savings/ retirement/education account(s) • Other – if within $300 of the maximum	• New checking/savings/ retirement/education account(s) • Other – if within $300 of the maximum
Income – Nonexempt including Lump Sums	Total gross amount	Total gross amount	• Total gross amount • Accept self-declaration of interest, unless from a new source or the amount changed by more than $50
Income - Terminated	When terminated in the application month or prior two months, verify: • Source • Final gross amount • Date received • Reason terminated • Termination date	Verify source, final gross amount, date received, reason terminated, and termination date for: • Any loss of income • Loss of income for new member	Verify source, final gross amount, date received, reason terminated, and termination date for: • Any loss of income • Loss of income for new member
Deductions – Dependent Care Costs	Total amount	New amount	Total amount
Deductions – Child Support	Total amount	New amount	Total amount
Deductions – Alimony and Payment to Persons Outside the Home	Total amount	New amount	Total amount
School Attendance	School age children applying	New school age children applying	• Certified school age children • New school age children applying
Management	If the household's basic expenses are paid or delinquent, when management is questionable	Not Applicable	If the household's basic expenses are paid or delinquent, when management is questionable
Employment Services	All exemptions	Any new exemptions	All exemptions
Federal Time Limits (FTLs)	• Out-of-state benefits received on or after October 1999 • Hardship exemptions for adults applying	• Out-of-state benefits received on or after October 1999 • Hardship exemptions for new adults applying	• Out-of-state benefits on or after October 1999 • Hardship exemption for new adults applying
Personal Responsibility Agreement (PRA)	• Child Support cooperation • Voluntary quit • School Attendance • Household was in cooperation with PRA requirements according to policy in A-2131.1, Initial Application	Not Applicable	All certified members are complying with all PRA components: • Choices • Child Support • Drug/Alcohol • Immunizations • Parenting Skills • School Attendance • Texas Health Steps • Voluntary Quit

Mandatory Verifications	At Application	When a Change Occurs	At Redetermination
PRA – When in Pay for Performance	All certified members are complying with all PRA components: • Choices • Child Support • Drug/Alcohol • Immunizations • Parenting Skills • School Attendance • Texas Health Steps • Voluntary Quit	Not Applicable	Not Applicable
Workforce Orientation	Compliance by caretaker and second parent applying who are not disqualified and reside in a full service Choices county	Compliance by any new caretaker or second parent being added who are not disqualified and reside in a full service Choices county.	Compliance by any new caretaker and second parent applying who are not disqualified and reside in a full service Choices county
One-Time Temporary Assistance for Needy Families (OTTANF)	Crisis criteria	Not Applicable	Not Applicable

C—912 Required Verification for SNAP

Revision 17-3; Effective July 1, 2017

SNAP

Mandatory Verification	At Application	When a Change Occurs	At Redetermination *
Household Composition	• household size, if questionable; • eligible status of each household member whose individual eligibility is questionable; • new Texas residents applying, verify any out-of-state disqualifications for intentional program violation and/or a felony drug conviction; • compliance with parole or community supervision for individuals with a felony drug conviction on or after September 1, 2015; • whether a felony drug conviction is: ◦ subsequent to another felony drug conviction on or after September 1, 2015; and ◦ received while the individual was receiving SNAP.	• if change reported makes household size questionable; • new members who are new Texas residents, verify any out-of-state disqualifications for intentional program violation and/or a felony drug conviction; • new members with a felony drug conviction on or after September 1, 2015, verify compliance with parole or community supervision; • new members with a felony drug conviction, verify whether the conviction is: ◦ subsequent to another felony drug conviction on or after September 1, 2015; and ◦ received while the individual was receiving SNAP.	• household size, if questionable; • new members who are new Texas residents, verify any out-of-state disqualifications for intentional program violation and/or a felony drug conviction; • compliance with parole or community supervision for individuals with a felony drug conviction on or after September 1, 2015; • whether a felony drug conviction is: ◦ subsequent to another felony drug conviction on or after September 1, 2015; and ◦ received while the individual was receiving SNAP.

Mandatory Verification	At Application	When a Change Occurs	At Redetermination *
Citizenship	If questionable, or if a regional requirement.	If questionable, or if a regional requirement.	If questionable, or if a regional requirement.
Alien Status	Household members identified as aliens.	New members identified as aliens.	• new members identified as aliens; and • when the U.S. Citizenship and Immigration Services (USCIS) document has expired.
Social Security Number (SSN)	Household members who cannot provide an SSN, verify they applied for an SSN, unless exempt.	New members who cannot provide an SSN, verify they applied for an SSN, unless exempt.	Household members who cannot provide an SSN, verify they applied for an SSN, unless exempt.
Identity	Individual being interviewed (also, identity of case name if authorized representative is interviewed).	Individual being interviewed, if not previously verified, or if questionable.	Individual being interviewed, if not previously verified, or if questionable.
Residence**	• physical address; and • the last month a member received benefits in another state.	The last month any new member received benefits in another state.	• physical address; and • the last month any new member received benefits in another state.
Resources**	• checking, savings, retirement, education account(s); and • other, if within $300 of the maximum. **Note:** If the total combined balance for all checking/savings accounts does not exceed $1,000 on the day of the reported change and is not questionable, accept the individual's statement. Pend the Eligibility Determination Group (EDG) only if the reported account balance is questionable or it exceeds $1,000.	• new checking, savings, retirement, education account(s); and • other, if within $300 of the maximum. **Note:** If the total combined balance for all checking/savings accounts does not exceed $1,000 on the day of the reported change and is not questionable, accept the individual's statement. Pend the EDG only if the reported account balance is questionable or it exceeds $1,000.	• new checking, savings, retirement, education account(s); and • other, if within $300 of the maximum. **Note:** If the total combined balance for all checking/savings accounts does not exceed $1,000 on the day of the reported change and is not questionable, accept the individual's statement. Pend the EDG only if the reported account balance is questionable or it exceeds $1,000.
Income – Nonexempt including Lump Sums	Verify total gross amount.	Verify total gross amount.	• Verify total gross amount; and • accept self-declaration of interest, unless from a new source or the amount changed by more than $50.
Income – Terminated	If terminated in the application month or prior two months, verify: • source; • final gross amount; • date received; • reason terminated; and • termination date.	Verify source, final gross amount, date received, reason terminated and termination date for: • any loss of income; and • loss of income for new member.	Verify source, final gross amount, date received, reason terminated and termination date for: • any loss of income; and • new member (See A-1370, Verification Requirements, for streamlined reporting requirements).
Deductions – Child Support	• legal obligation to pay; • amount of obligation; and • amount actually paid.	• amount actually paid; and • a change in legal obligation.	• amount actually paid; and • a change in legal obligation.
Deductions – Dependent Care	Total amount if verification can be obtained at the interview.	A new amount. **Note:** If the amount cannot be	Total amount if verification can be obtained at the interview.

Mandatory Verification	At Application	When a Change Occurs	At Redetermination *
Costs	**Note:** If verification cannot be obtained during the interview and the total expense does not exceed $300 a month, total for the entire EDG, and is not questionable, then accept the individual's statement. Pend the EDG only if the claimed expense is questionable or exceeds $300 a month, total, for the entire EDG.	verified and is less than $300, accept the individual's statement. Pend the EDG only if the reported expense is questionable or exceeds $300 a month, total, for the entire EDG.	**Note:** If verification cannot be obtained during the interview and the total expense does not exceed $300 a month, total for the entire EDG, and is not questionable, then accept the individual's statement. Pend the EDG only if the claimed expense is questionable or exceeds $300 a month, total, for the entire EDG.
Deductions – Actual and Standard Medical Expenses	Refer to A-1428.2, Budgeting Medical Deductions.	Refer to A-1428.2, Budgeting Medical Deductions.	Refer to A-1428.2, Budgeting Medical Deductions.
Deductions – Shelter	• Rent or mortgage, if questionable, or if this information is a regional requirement. • The total amount of shelter cost for an unoccupied home.	• If change in rent or mortgage is questionable, or if this information a regional requirement. • The total amount of shelter cost for an unoccupied home, if amount changed.	• Rent or mortgage, if questionable, or if this information is a regional requirement. • The total amount of shelter cost for an unoccupied home.
Management	If the household's basic expenses are paid or delinquent, when management is questionable.	Not Applicable	If the household's basic expenses are paid or delinquent, when management is questionable.
Employment Services	• exemptions that are questionable; • any member claiming to be physically or mentally unable to work, if not obvious; • any member claiming an exemption based on caring for a person with a disability living in the home; • at least 30 hours worked if a self-employed individual does not receive earnings equal to 30 hours multiplied by the federal minimum wage (Code P); and • a refugee is participating, at least half-time in a training program administered by a refugee contractor or Match Grant Program (Code S).	• new exemptions that are questionable; • any new member claiming to be physically or mentally unable to work, if not obvious; and • any new member claiming to be caring for a person with a disability living in the home.	• exemptions that are questionable; • any new member claiming to be physically or mentally unable to work, if not obvious; and • any new member claiming to be caring for a person with a disability living in the home.
Federal Time Limits – 18-50 Work Requirement, Able-Bodied Adult Without Dependents (ABAWD)	Individual's exemption from requirement is based on: • pregnancy or being physically or mentally unfit to work 20 hours a week; • participation in the Workforce Innovation and Opportunity Act (WIOA) or the Trade Adjustment Act Program; • participation in the Supplemental Nutrition Assistance Program (SNAP)	Individual's exemption from requirement is based on • pregnancy or being physically or mentally unfit to work 20 hours a week; • participation in WIOA, the Trade Adjustment Act Program, or the SNAP E&T program using Form H1822 • that the employee works an average of 20 hours a	• individual's exemption from requirement is based on pregnancy or being physically or mentally unfit to work 20 hours a week; • participation in WIOA, the Trade Adjustment Act Program, or the SNAP E&T program using Form H1822 • that the employee works an average of 20 hours a week, if employed; • verify the individual worked or complied with a work program for

Mandatory Verification	At Application	When a Change Occurs	At Redetermination *
	Employment and Training (E&T) program using Form H1822, ABAWD E&T Work Requirement Verification • that the employee works an average of 20 hours a week, if employed; • verify the individual worked or complied with a work program for at least 80 hours in a 30-period for eligibility of the second three months of time-limited benefits; • volunteer employment hours • countable months of benefits received in another state.	week, if employed; • verify the individual worked or complied with a work program for at least 80 hours in a 30-day; • volunteer employment hours; • countable months of benefits received in another state.	at least 80 hours in a 30-day; • volunteer employment hours; and • countable months of benefits received in another state.
Elderly or Household Members with a Disability	If not previously verified: • household members are age 60 or older; and • household members meet the disability criteria in B-432, Definition of Disability.	If not previously verified: • household members are age 60 or older; and • household members meet the disability criteria in B-432, Definition of Disability.	If not previously verified: • household members are age 60 or older; and • household members meet the disability criteria in B-432, Definition of Disability.

* Requirements are the same for all redeterminations whether filed timely or untimely.

** Categorically eligible households in which all members receive Temporary Assistance for Needy Families (TANF) cash assistance (TP 01/61) and/or Supplemental Security Income (SSI) are exempt from verification.

Note: Verify the eligible status of the facilities listed below as required in B-400, Special Households:

- homeless shelters;
- group living arrangements;
- drug and alcohol treatment centers; and
- family violence shelters.

C—913 Required Verification for Medical Programs

Revision 24-2; Effective April 1, 2024

Medical Programs

Mandatory Verifications	At Application	When a Change Occurs*	At Redetermination
Citizenship except TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36	All household members applying	Any new member applying	Any new member applying
Alien Status Exception: The Systematic Alien Verification for Entitlements (SAVE) procedures do not apply to an alien in TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36 who does not meet citizenship or alien status requirements, unless the person potentially meets the citizenship or alien status requirement for another program	Any person identified as an alien who wishes to be certified	Any new person identified as an alien who wishes to be certified	Any new person identified as an alien who wishes to be certified

Mandatory Verifications	At Application	When a Change Occurs*	At Redetermination
Social Security Number (SSN) except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, and TP 45	• All household members who are applying • Household members who are applying who cannot provide an SSN, verify they applied for an SSN, unless exempt	• New members who are applying • New members who are applying who cannot provide an SSN, verify they applied for an SSN, unless exempt	• Household members who are applying • Household members who are applying who cannot provide an SSN, verify they applied for an SSN, unless exempt
Age or Relationship	All children applying; and if not available, accept self-declaration For TP 08, if not available, follow the policy in A-523.1, How to Make an Evaluative Conclusion.	Newly added children and if not available, accept self-declaration For TP 08, if not available, follow the policy in A-523.1.	Newly added children and if not available, accept self-declaration For TP 08, if not available, follow the policy in A-523.1.
Identity except TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36	All people requesting benefits When an interview is required, the identity of the person being interviewed must be verified.	Any new member requesting benefits	Any new member requesting benefits When an interview is required, the identity of the person being interviewed must be verified.
Residence **Note:** Accept self- declaration for Children's Medicaid and TP 56 for a child	• Physical address • Intent to remain in Texas • New Texas residents, verify the last month the member received Medicaid in another state	Not Applicable	• Physical address • Intent to remain in Texas • New Texas residents, verify the last month any new member received Medicaid in another state
Three Months Prior	• Unpaid medical bills • Income for each of the months of prior coverage. Review A-831.2, Eligibility for Three Months Prior Coverage, for TP 40	Not Applicable	Not Applicable
Third-Party Resources	• Any household member applying who has private health insurance	• For each certified household member whose coverage has changed • New members applying who have private health insurance	• For each certified household member whose insurance coverage has changed • New members applying who have private health insurance
Pregnancy (TP 40 and TP 36)	Accept self-declaration for pregnancy, pregnancy start date, number of children expected and the anticipated date of delivery.	Not Applicable	Not Applicable
Medicaid Eligibility of Mother (TP 45 only)	For each certified child	For a newly certified child	For each certified child
Emergency Medical Condition Treatment (TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36)	For each certified undocumented alien or ineligible alien treated for an emergency condition	Not Applicable	Not Applicable

Mandatory Verifications	At Application	When a Change Occurs*	At Redetermination
Resources* (Children on TP 56, Children on TP 32, and TP 02 only)	• Checking or savings or retirement or education account(s) • Other – if within $300 of the maximum	• New checking or savings or retirement or education account(s) • Other – if within $300 of the maximum	• New checking or savings or retirement or education account(s) • Other – if within $300 of the maximum
Income – Nonexempt including Lump Sums*	• Total gross amount **Note:** Frequency is self-declared for Children's Medicaid***	• Total gross amount **Note:** Frequency is self-declared for Children's Medicaid***	• Total gross amount • Accept self-declaration of interest, unless from a new source or the amount changed by more than $50 **Note:** Frequency is self-declared for Children's Medicaid***
Income – Terminated	If terminated in the application month or prior two months, verify: • Source • Final gross amount • Date received • Reason terminated • Termination date **Note:** For Children's Medicaid***, verify only income that terminated in the month of application.	Verify source, final gross amount, date received, reason terminated, and termination date for: • Any loss of income • Terminated income of new member	Verify source, final gross amount, date received, reason terminated, and termination date for: • Any loss of income • Terminated income of new member **Note:** For Children's Medicaid, verify only income that terminated in the application month for new members.
Modified Adjusted Gross Income (MAGI) Expenses	Total amount	New amount	Total amount
School Attendance (TP 08 only)**	For the dependent child(ren) that makes the parent or caretaker relative eligible, if they are 18 only child	For the dependent child(ren) that makes the parent or caretaker relative eligible if they are 18	For the dependent child(ren) that makes the parent or caretaker relative eligible if they are 18
Child Support — Good Cause Claims (TP 08 only)	Any good cause claim	Good cause claim for new children applying	Good cause claim for new children applying **Note:** All good cause claims must be re-evaluated at redetermination.
Domicile (TP 08 only)	For a dependent child	When a change impacts the living situation or care and control of the dependent child	For a dependent child
Household Composition — Family Violence Exemption	Any family violence exemption	Any new family violence exemption	Any new family violence exemption
Management except: TP 40 and Children's Medicaid* **	If the household's basic expenses are paid or delinquent, when management is questionable	Not Applicable	If the household's basic expenses are paid or delinquent, when management is questionable

* * Children certified on TP 43, TP 44, TP45 and TP 48 are continuously eligible for 12 months. Address changes in income as explained in B-600, Changes.

** School attendance is only verified if the **only** child that makes the parent or caretaker relative eligible for TP 08 is 18 years.

*** Children's Medicaid simplified verification requirements also apply when processing a Medically Needy with Spend Down (TP 56) or Medically Needy with Spend Down — Emergency (TP 32) EDG for a child under 19.

C-920, Questionable Information

Body

Revision 15-4; Effective October 1, 2015

All Programs

Consider the individual's statements on the application or during the interview questionable if they:

- are contradictory;

  (**Example:** The individual states he has had no income for several months, but his application shows $30 cash on hand.)

- do not agree with information in the case record;

  (**Example:** The individual states he has no resources. An earlier application was denied because bank accounts and property were over the resource limits.)

- do not agree with other information the advisor has;

  (**Example:** The individual provides paycheck stubs showing a 40-hour week in an industry such as construction that has frequent overtime.)

- do not adequately explain the household's circumstances; or

  (**Example:** The individual states he has not paid rent or utilities for several months, but he has not been evicted or had his utilities cut off.)

- do not agree with information obtained from precertification activity, such as information retrieved from the Data Broker System's Employer New Hire Report (ENHR) or another automated source.

Note: The ENHR and other sources in Data Broker may list the corporate name and address instead of the local business name and address. Before denying an EDG, consider that the commonly known name of a business may be different from the corporate name.

Before taking adverse action, allow the individual an opportunity to resolve any discrepancy by providing documentary proof or designating a suitable collateral source.

After the initial application or redetermination interview, if the advisor obtains unverified information from a source other than the individual which contradicts the individual's statement, then the advisor may:

- allow the applicant an opportunity to resolve the discrepancy, or
- verify the information by directly contacting a collateral source.

  Example: The individual states on the application and at the interview that the household has no income from wages. The advisor contacts the landlord to verify residence, and the landlord reports the applicant is working. The advisor may either contact the individual or the employer to verify the information.

Sources of verification are listed at the end of each applicable section in the *Texas Works Handbook*.

C-930, Providing Verification

Body

C—931 Household Responsibility for Providing Verification

Revision 19-1; Effective January 1, 2019

All Programs

Households or the independent child's representative have the primary responsibility for providing documented or collateral evidence needed for proof of their circumstances. Households do not need to designate a collateral source if that source is named on the application form or during the interview or application processing. The advisor may assist the household in designating a collateral contact by suggesting a source that may be reliable.

If documented evidence is not available or not sufficient, the household must:

- designate an alternate source of verification; or
- permit a prescheduled home visit.

Exception: Law enforcement have the primary responsibility for providing verification that a person is a fleeing felon, a probation violator or a parole violator. Households are not responsible for providing proof of their fugitive status.

C—932 Advisor Responsibility for Verifying Information

Revision 20-4; Effective October 1, 2020

All Programs

When verifying information, follow these guidelines:

- Photocopy and send for imaging all paper documents a person provides as verification. If the household indicates that a document is verification for more than one case, send for imaging for each case.
- Do not reverify eligibility factors previously verified and not subject to change, if the previous verification is available in the electronic case record. (**Examples:** relationship, birth or citizenship proof, and deprivation due to death.)
- Do not request additional information or documentation from households unless such information is not available electronically or the information obtained electronically is not consistent with the information on the application.
- Do not ask a person to provide additional proof if:
    - verification is available through the Texas Integrated Eligibility Redesign System (TIERS) inquiry, Texas Workforce Commission (TWC) inquiry, the Birth Verification System (BVS), Child Support inquiry, or other automated systems that are acceptable verification sources and accessible to staff, or if the person indicates that verification is readily available in the electronic case record; and
    - the information is sufficient to establish current eligibility.
- Do not verify income information by using 1-900 telephone numbers. Accessing these numbers results in a substantial charge ($2 - $20 per call) to the Texas Health and Human Services Commission (HHSC).
- Accept any reasonable evidence provided by the household whether it is provided in person, by mail, fax, other electronic device or via an authorized representative. Verification should be reliable and sufficient to prove a person’s statement.
- Determine what types of verification are readily available to the household and request that verification first if it is anticipated to be sufficient proof. If preferred sources of verification are not readily available, alternate sources of proof must be accepted if they are reliable and provide sufficient proof. Sources of documentary proof and collateral sources are listed at the end of the applicable section of the *Texas Works Handbook*.
- Do not disclose any information the household provides when contacting a third party for verification. Do not disclose that the household has applied for any specific program or suggest the household is suspected of any wrong doing.

  Note: If the collateral source asks why the information is necessary, inform the collateral source that HHSC is required to verify eligibility for assistance. If the collateral source asks for specific information regarding the person, inform the collateral source of the person's confidentiality rights.
- Evaluate the documented evidence or collateral source the household provides and determine if it is reliable and sufficient to determine eligibility and benefit amount. If a source of verification is unreliable:
    - designate another collateral source;
    - ask the household to designate another collateral source; or
    - schedule a home visit. Do not conduct a home visit solely because the household meets error-prone criteria.

      Note: HHSC may also designate a collateral source if the person fails to provide one.
- Contact the designated collateral source unless the person claims it will result in negative consequences, such as eviction or loss of job.
- Offer reasonable assistance in obtaining verification if the person has difficulty in obtaining the required verification. Also, offer assistance if discrepancies exist in the documentary information the person provides or if they request assistance in clearing the discrepant information.
- Accept collateral sources or documents from the household that are reliable and provide sufficient proof. Do not deny or delay benefits if this requirement is met, or if:
    - a collateral source refuses to provide verification; and
    - there is no reasonable alternate verification available.
- There may be unusual circumstances in which a person's statement must be accepted as proof if:
    - there is a reasonable explanation why documentary evidence or a collateral source is not available; and
    - the person's statement does not contradict other statements or other information received by staff.

Exception: For verification of relationship, follow procedures in A-522, Legal Parent-Child Relationship, and A-540, Documentation Requirements.

- If a person can cooperate but clearly indicates orally or in writing that they refuse to take action necessary to complete the certification process, deny the EDG. This also applies to evaluations such as audits, quality control or investigations. See A-1324.18, Temporary Assistance for Needy Families (TANF), for action required on a SNAP EDG when the associated TANF EDG is denied due to any of these reasons.
- Have the person sign Form H0003, Agreement to Release Your Facts, for collateral sources that will not release information without the person's written consent.
  Note: Do not request signatures on blank forms for future use.

- For people born in Puerto Rico, HHSC can submit a birth verification request by mail, fax or email to the Department of Healthcare Demographic Registry Office of Puerto Rico. Include in the request the person's name as it appears on the birth certificate (including both last names if more than one last name), the person's date of birth and place of birth.

  To submit a request by:

  - email, send the request to Registrodemografico@salud.gov.pr. In the request, indicate the government email address to which the response should be sent.
  - fax, make the request on official letterhead and fax it to the attention of Validation Office at 787-767-8605 or 787-766-1299. Indicate in the fax the government fax number to which the response should be sent.
  - regular mail, make the request on official letterhead and mail it to the attention of Validation Office, Demographic Registry Office of Puerto Rico, Department of Health, P.O. Box 11854, San Juan, Puerto Rico 00910. Indicate in the letter the full mailing address to which the response should be sent.

  Within two business days, the Registry Office will verify the person's submitted demographic information or will advise that the submitted information is inconsistent with the information in the Registry Office.

Document collateral sources that are designated orally by the individual or by HHSC.

Exception: Do not pend for, or attempt to obtain, the verification of fugitive status for fleeing felons or probation or parole violators from the household. Law enforcement provides verification of fugitive status to HHSC when they are actively seeking to apprehend people.

Medical Programs except Emergency Medicaid

Assist a person in obtaining documentary evidence of citizenship. Identify if they cannot to provide documentary evidence of citizenship in a timely manner because of incapacity of mind or body or the lack of a representative to assist. Assisting a person consists of referrals to appropriate entities that can help them. Follow A-358.1, Citizenship, when assisting a person with providing documentary evidence of citizenship and identity.

Related Policy

Citizenship, A-358.1
Legal Parent-Child Relationship, A-522
Documentation Requirements, A-540
Temporary Assistance for Needy Families (TANF), A-1324.18

C-940, Documentation

Body

Revision 15-4; Effective October 1, 2015

All Programs

Document in TIERS Data Collection and in Case Comments information to support all decisions about eligibility and allotment, whether at application, change, or redetermination. Documentation must be sufficient so that anyone can understand all computations and advisor decisions, including denials.

Always include the following:

- mandatory verifications;
- why information is questionable;
- how questionable information is cleared;
- why alternate methods are used rather than standard methods;
- why one collateral contact was rejected in preference for another;

- name, address, and/or telephone number for all collateral contacts; and
- documentation in the Agency Use Only section of the application or redetermination forms or change report form for address changes regarding voter registration actions provided to the individual.

Document contacts between redeterminations that may affect eligibility or benefit amount. **Note:** Documentation requirements are listed at the end in the applicable section in the *Texas Works Handbook*.

SNAP

Always document why another verification source such as a collateral contact or home visit was necessary (except when using a collateral contact to verify where the household lives or its size).

Related Policy

Registering to Vote, A-1521
The Texas Works Documentation Guide

C—941 Texas Works Documentation Guide

Revision 13-1; Effective January 1, 2013

All Programs

TIERS Data Collection pages handle the majority of required documentation for a case record. The documentation requirements not captured by these pages have been compiled into a comprehensive documentation guide, *The Texas Works Documentation Guide*.

C-1000, Procedures for Clearance of Income & Eligibility Reports & Internal Revenue Federal Tax Information

C-1010, Clearance of IEVS Reports by the Office of Inspector General that Do Not Include IRS FTI

Body

C-1011 OIG IEVS Process

Revision 21-4; Effective October 1, 2021

TANF, SNAP and Medicaid

The IEVS module within the Automated System for Office of Inspector General (ASOIG) automates the creation, distribution and clearance of IEVS matches for OIG staff. OIG staff review matches from certain IEVS worksheets (primarily Unemployment Insurance Benefits [UIB] and Wage) as a detection source to identify potential fraud, waste or abuse by current or former recipients. OIG uses the IEVS module to process and clear IEVS matches assigned to the OIG Program Integrity Intake unit within 45 days.

C-1012 Review the Case Record

Revision 21-4; Effective October 1, 2021

TANF, SNAP and Medicaid

When processing an IEVS match, OIG staff may review case data in Texas Integrated Eligibility Redesign System (TIERS) and the TIERS Historical Case Report (THCR) to determine application entries, interview responses, other eligibility factors and benefits issuance details and history.

OIG staff research the complete action that occurred before the relevant IEVS income date(s). If the information associated with the match is not found for the period in question in the most recent eligibility action, OIG staff review all actions from the period in question through the current action.

OIG staff may:

- review Data Broker for sources of income by checking Texas Workforce Commission (TWC) Wage Detail, Unemployment Insurance Benefits (UIB) and the Employer New Hire Report (ENHR);
- review other available sources of income information; and
- document findings on the worksheet in the ASOIG IEVS module.

Related Policy

Employer New Hire Report (ENHR) and National Directory of New Hires (NDNH) Report, C-825.12
Texas Workforce Commission (TWC) Wage/Benefits, C-825.13

C-1013 Request Verification

Revision 21-4; Effective October 1, 2021

TANF, SNAP and Medicaid

OIG Benefits Program Integrity (BPI) staff request verification if the IEVS Match information on wages:

- was not reported or budgeted correctly in TIERS; or
- was budgeted in the case but the IEVS Match discrepancy amount for an individual employer is more than $300 per month or household income exceeds 130% of the federal poverty level (FPL).

In these situations, verification is required to determine if the income is ongoing and affects current benefits, the income causes an overpayment or both.
OIG BPI staff obtain verification by:

- calling the employer;
- accessing Data Broker; or
- sending an OIG verification letter to the individual and payer.

OIG staff allow at least 10 days from the print date of the letter for the person or payer to provide verification. The request for verification letter informs the recipient that the information is needed because OIG is reviewing the case to determine if benefits were issued correctly.

C-1014 OIG IEVS Income Action Messages

Revision 21-4; Effective October 1, 2021

TANF, SNAP and Medical Programs (Except TP 40, TP 43, TP 44 and TP 48)

OIG staff may create an income action message in the ASOIG IEVS module for the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) program and Medicaid programs, except for TP 40, TP 43, TP 44 and TP 48. The income action message alerts interview staff that more action may be necessary because available information indicates that income is ongoing or resources exist that may affect current eligibility or benefits.

OIG staff summarize findings in the comment section of the income action message. Customer Care Center (CCC) staff view detailed information regarding the income from the automated IEVS match worksheet within ASOIG.

There are three different types of action or information messages that OIG may create in the ASOIG IEVS module.

OIG creates a(n)...	When...
Income Action Message **Note**: *Action messages created based on IRS FTI are limited to those matches with a source listed as "Self" or "Earn."*	• verifying whether a matched person's ongoing income affects current eligibility or benefits for the household; or • the matched person fails to provide verification of ongoing income. (OIG creates an overpayment referral for the time period listed on the IEVS match if the worksheet indicates that resources affect prior eligibility.)

OIG creates a(n)...	When...
Resource Action Message	• verifying whether a matched person's resource affects current eligibility or benefits for the household (OIG completes overpayment referral, if appropriate); or • the matched person fails to provide verification of existing or ongoing resources. (OIG creates an overpayment referral for the time period listed on the IEVS worksheet if the matched resources affect prior eligibility.)
Resource Information Message	• the matched person's resource is ongoing and is under limit or inaccessible; • the matched person's resource is ongoing, the TIERS case status as of the review date is ongoing denied; or • the matched person did not provide verification to OIG and TIERS case status as of the review date indicates ongoing denied.

OIG staff summarize findings in the TW Comments section of the IEVS worksheet. View detailed information regarding the person's income, resources or both on the IEVS worksheet in the ASOIG IEVS module.

C-1020, Clearance of IEVS Reports by Texas Works Staff

Body

C-1021 Reserved for Future Use

Revision 21-4; Effective October 1, 2021

C-1022 OIG IEVS Action Message Clearance Process

Revision 21-4; Effective October 1, 2021

TANF, SNAP and TP 08

Designated CCC staff conduct a daily review of the "MATCH TW Alert Details" in the ASOIG IEVS module and assign HHSC IEVS staff to review and take steps to clear each action message.

HHSC IEVS staff create a task to clear the action message for cases in TIERS within two business days of receiving the message. If these tasks are assigned to specific units, the unit supervisor or a designee (such as a clerk) assigns the task to the appropriate staff by the next business day following receipt. Staff must complete the change within 10 days after the date it is assigned. The date of assignment is day zero.

When an IEVS MATCH TW action message is generated based on IRS FTI, the action or resource message will be on a screen clearly labeled with an FTI warning. All information in the IEVS module containing FTI (such as payer name, account number or pay amounts) is considered IRS FTI. If staff print IEVS module worksheets, they must secure them according to IRS safeguard requirements.

Each worksheet with a message from OIG BPI will indicate the type of action required. OIG BPI staff process action messages if the household did not provide accurate information during the interview or application processing, or if the increase in income identified via IEVS caused the household income to exceed 130% Federal Poverty Level (FPL) for SNAP streamlined reporting (SR) households.

Upon receipt of an action message, HHSC IEVS staff must take the following action to clear the message based on the reason the message was issued.

If the ...	then HHSC IEVS staff ...
verification provided to OIG BPI indicates income affects current eligibility,	• send manual Form H1017, Notice of Benefit Denial or Reduction, to deny or reduce the benefits based on income or resources. If staff do not receive verification from OIG, then document that OIG has the verification. Copies of verification received by OIG may be provided to Texas Works staff upon request. • provide advance notice and process the denial or adjustment after the adverse action period expires.
person fails to provide verification to OIG BPI,	• send a manual Form H1017 to deny the benefits for failure to provide the information. **Note**: A manual notice and denial is required because TIERS will not allow a denial for failure to provide information without previously issuing Form H1020, Request for Information or Action.

If the ...	then HHSC IEVS staff ...
	• for Non-FTI Alerts: In the comments section, document the information the person failed to provide and what the person can do to re-establish eligibility as specified in the Form H1017 instructions. If the person fails to provide the requested information within the adverse action time frame, process the denial for failure to provide information. • for FTI Alerts: In the comments section, document the following message: ◦ "You failed to provide information to the Office of Inspector General. Contact [OIG investigator's name] at [investigator's phone number] if you have questions. You may reapply for benefits and will be required to provide the information previously requested." ◦ "Usted no presentó información a la Fiscalía General. Si tiene alguna pregunta, comuníquese con [OIG investigator's name] al [investigator's phone number]. Puede volver a solicitar beneficios, pero tendrá que presentar la información que se le pidió anteriormente." • if the person fails to provide the requested information within the adverse action time frame, manually process the denial for failure to provide information. **Note**: A manual notice and denial is required because TIERS will not allow a denial for failure to provide information without previously issuing Form H1020. • if verification is provided within the adverse action time frame, send an email to the OIG investigator notifying the investigator about receipt of the information and include a copy of the verification. Take action on the case based on the verification provided.

Notes:

- The investigator's name and phone number are listed on the automated worksheet in the IEVS module.
- If HHSC IEVS staff do not provide the case record within 10 days or upon OIG BPI request, OIG BPI staff will contact the regional director.

Additional Information Regarding IRS FTI MATCH TW Action Messages

If HHSC IEVS determines that the person does not have the resource or income for which OIG requested information, staff must request verification of the information (including IRS FTI) using a manual Form H1020, Request for Information or Action. If attaching a verification form, such as a bank verification form or Form H1028, Employment Verification, do not include any IRS FTI on the verification form. File the manual Form H1020 in the case record and secure the case according to the IRS safeguarding requirements, because the case record now contains IRS FTI.

When the person provides the information requested on the verification form, the information on the verification form is no longer considered IRS FTI. The file copy of Form H1020 remains IRS FTI and must be kept in the case record for the duration of the retention period.

When requesting more information that does not contain IRS FTI, staff may issue a second Form H1020 through TIERS or request the information on a manual Form H1020.

Note: If HHSC IEVS staff complete a manual Form H1020 because the only required verification is IRS FTI, TIERS will not allow a denial based on failure to provide verification, since Form H1020 was not generated via TIERS. Staff may generate Form H1020 indicating a manual Form H1020 was provided to the person. Do not provide the notice generated from TIERS to the person. Document the reason for generating an electronic pending notice in the case comments and reference the manual Form H1020 that was issued.

If the person fails to provide the information, issue a manual Form H1017 to deny the case for failure to provide information.

C-1023 Reserved for Future Use

Revision 21-4; Effective October 1, 2021

C-1024 Client Reapplies

Revision 21-4; Effective October 1, 2021

TANF, SNAP and TP 08

If a person reapplies after being denied for failure to provide information to OIG, interview staff must obtain the verification requested by OIG before recertifying the case. If the person indicates the verification was provided to OIG, contact the OIG investigator. **Exception**: If the person can reasonably explain why the requested information cannot be obtained or provided, use the best available information.

Note: For FTI-related information, if the person self-discloses the information on the application that was observed through an IEVS FTI action message, the information is no longer considered IRS FTI.

Related Policy

Questionable Information, C-920

C-1025 Appeals

Revision 21-4; Effective October 1, 2021

TANF, SNAP and TP 08

If staff receive a request for an appeal based on action taken by:

- OIG, contact the OIG via the Benefits Program Integrity (BPI) mailbox on the same day the request is received.
- Eligibility staff as a result of an action message, file the appeal. Complete Form H4800, Fair Hearing Request Summary, and Form H4800-A, Fair Hearing Request Summary (Addendum). On Form H4800-A, Section 2, Materials Attached, indicate under Other Related Materials, that action messages generated by OIG need to be considered in the appeal. Enter the OIG Investigator's name and phone number on Form H4800, indicating the OIG investigator as potential resource witness.

If OIG receives a request for an appeal based on action taken by eligibility staff, OIG will notify the Central Representation Unit (CRU) the same day. CRU will coordinate with the eligibility staff person who took the action based on the action message. If the appeal is related to an IRS FTI match, OIG may assist by providing more information to the hearing officer according to IRS requirements for safeguarding FTI.

C-1026 HHSC IEVS Information Message Review Process

Revision 21-4; Effective October 1, 2021

TANF, SNAP and TP 08

At the region's discretion, staff may contact HHSC IEVS staff to review the messages in the IEVS module before certification of benefits. Information messages serve as a case clue to eligibility staff to identify potential resources not reported by the person applying for benefits.

When a MATCH TW Message is generated based on IRS FTI, the action or resource message will be on a screen clearly labeled with an FTI warning. When based on an FTI match, consider all associated information on the IEVS module such as payer name, account number and pay amounts, as IRS FTI. While eligibility staff are not prohibited from printing IEVS module worksheets with MATCH TW Messages, staff must secure these worksheets per safeguarding requirements.

C-1030, Reversed for Future Use

Body

Revision 21-4; Effective Oct. 1, 2021

C-1040, Reversed for Future Use

Body

Revision 21-4; Effective October 1, 2021

C-1050, IRS FTI Security and Protection

Body

Revision 24-3; Effective July 1, 2024

All Programs

Federal Tax Information (FTI) includes tax returns or return information received directly from the IRS or obtained through an authorized secondary source such as the Social Security Administration. Staff must protect digital and non-digital media containing FTI from unauthorized inspection and disclosure. Digital media includes a computer, mobile device and removable storage, such as CDs, DVDs and external hard drives. Non-digital media includes a paper form, report and log.

HHSC limits FTI access to staff whose duties require access. HHSC agency and non-agency staff access FTI physically and through the Automated System for Office of Inspector General (ASOIG). Staff must handle FTI using the following policies to ensure information does

not become misplaced, stolen, or made available to unauthorized personnel.

TANF, SNAP and TP 08

HHSC IEVS staff must retain electronic IEVS worksheets for five years. Staff may log and destroy any printed IEVS module records using IRS safeguarding requirements once they are no longer needed because the electronic records are available and kept in ASOIG for the applicable retention period.

The following forms must be kept for five years from the date of the last entry on the form:

- Form H1861, Federal Tax Information Record Keeping and Destruction Log;
- Form H1862, Federal Tax Information Transmittal Memorandum;
- Form H1863, Federal Tax Information Removal Log;
- Form H1864, Federal Tax Information Fax Transmittal; and
- Form H1866, Federal Tax Information Visitor Access Log.

C-1051 IRS FTI Security and Awareness Training

Revision 24-3; Effective July 1, 2024

All Programs

HHSC and non-HHSC staff who access or may potentially encounter FTI must take and pass the annual Safeguarding IRS Federal Tax Information training to receive and maintain their access permissions to ASOIG. HHSC staff access the training course under System Training Solutions (STS) in the Centralized Accounting and Payroll/Personnel System (CAPPS). Non-HHSC staff may contact the HHSC IRS Coordinator by email at the HHSC AES Federal Tax Info Training Mailbox to get a copy of the training.

HHSC developed the Safeguarding IRS Federal Tax Information training with role-based job aids as an agency resource for security and privacy awareness. HHSC updates this training on an annual basis to reflect any system and policy changes and address audit findings.

Upon completion of the Safeguarding IRS Federal Tax Information training, HHSC staff submit a confirmation of understanding in STS. The confirmation acknowledges staff completed a thorough review of the web-based training and job aids in the resources tab relevant to their professional role. Additionally, it confirms understanding of incident reporting requirements. STS maintains a record of completion for each employee. Non-HHSC staff must review a PDF version of the training, sign Form H4096, Safeguarding Information Certification, and submit the form to their management. The form confirms completion and understanding of the material within the training, as well as the penalties involved for any unauthorized inspection and disclosure of FTI. Non-HHSC management must maintain a copy of the Form H4096 in the employee's file.

HHSC staff must also complete the HHS Information Security/Cybersecurity Awareness Training and the HHS Privacy Training within 30 days from their hire date and before accessing ASOIG. These trainings are available in STS in CAPPS.

C-1052 Accessing IRS FTI

Revision 24-3; Effective July 1, 2024

All Programs

HHSC and non-HHSC staff are prohibited from using personally owned media on agency systems or system components. Staff are also prohibited from using portable storage devices in agency systems when such devices have no identifiable owner.

HHSC and non-HHSC staff must adhere to policies and procedures for the handling and protection of FTI to prevent unauthorized access and disclosure. Failure to adhere to the policies or procedures will result in disciplinary action, including warnings, access suspension, permanent access removal or termination.

HHSC and non-HHSC management notify their staff within 72 hours when the formal employee sanction process is initiated. The notification includes the staff member sanctioned and the reason for the sanction.

HHSC and non-HHSC management must remove system and physical access when their staff transfer or are reassigned to a position that no longer requires ongoing operational need to access FTI. HHSC and non-HHSC management submit a modified access request within 24 hours of the transfer or reassignment.

HHSC and non-HHSC management must remove system and physical access and discuss information security during an exit interview when employment is terminated. HHSC and non-HHSC management submit a modified access request within 24 hours of the termination.

Work areas where staff physically access FTI should be limited to authorized personnel only. These areas must be prominently posted and separated from non-restricted areas by physical barriers that control access. FTI must be secured during and after normal operating hours. Staff

accessing secured areas must clearly display a picture identification badge. The badge may not be obstructed and must be displayed above the waist.

Staff responsible for protecting access to FTI must mark system media containing FTI to show the distribution limitations, handling caveats and applicable security markings, if any. Additionally, staff responsible for protecting access to FTI must physically control and securely store media containing FTI within agency-controlled areas. Protect system media until it is sanitized or disposed of using approved equipment and methods.

C-1052.1 Minimum Protection Standards

Revision 24-3; Effective July 1, 2024

All Programs

Minimum protection standards (MPS) require the agency to use at least two barriers to protect FTI from unauthorized access. These barriers include a combination of secured perimeters, security rooms, badged employees and security containers.

- **Secured Perimeters** are enclosed by slab-to-slab walls constructed of durable materials and supplemented by periodic inspection. Any lesser-type partition must be supplemented by electronic intrusion detection and fire detection systems. All doors entering the space must be locked per Locking Systems for Secured Areas. In the case of a fence or gate, the fence must have intrusion detection devices or be continually guarded. The gate must be either guarded or locked with intrusion alarms.
- **Security Rooms** are constructed to resist forced entry. The entire room must be enclosed by slab-to-slab walls constructed of approved materials, such as masonry brick or concrete, and supplemented by periodic inspection. Door hinge pins must be non-removable or installed on the inside of the room. Access must be limited to specifically authorized personnel.
- **Badged Employees** can serve as the second barrier during business hours between FTI and unauthorized persons. The authorized personnel must wear picture identification badges or credentials. The badge must be clearly displayed and worn above the waist.
- **Security Containers** are storage devices, such as turtle cases, safes, vaults or locked IT cabinets, with resistance to forced penetration and a security lock with controlled access to keys or combinations.

C-1052.2 Locking Mechanisms

Revision 24-3; Effective July 1, 2024

All Programs

All buildings, rooms and containers containing FTI must be locked when not in actual use. Key or combination locking mechanisms may secure FTI. Staff not authorized to access FTI may have a key to the building but not the secured room. This includes unauthorized agency staff, contractors, security personnel, custodial staff and landlords.

The following guidelines apply to key locking mechanisms:

- The number of keys must be kept to a minimum.
- Only authorized staff can access the secured area.
- The unauthorized duplication of keys is prohibited.
- Keys must be returned before departure for staff who retire, terminate employment or transfer to another position.
- Management must conduct annual reconciliation of key records.

The following rules apply to combination locking mechanisms:

- The combination is only shared with authorized staff.
- The unauthorized disclosure of the combination is prohibited.

Management must change the combination at least annually or upon departure of staff that retire, terminate employment, or transfer to another position.

C-1052.3 Authorized Access, Visitor Access, and Authorized Personnel Lists

Revision 24-3; Effective July 1, 2024

All Programs

HHSC must maintain a visitor log and authorized access list (AAL) to record access to physical work areas containing FTI. Staff maintain Form H1866 as a record of visitor access to a restricted area. Security staff must validate a visitor’s identity by examining a government-issued identification, such as state issued identification, driver’s license or passport. An AAL is maintained and MPS enforced to facilitate the entry of staff who have a frequent and continuing need to enter a restricted area but who are not assigned to the area. The AAL must contain the following:

- name of employee, vendor, contractor or non-agency personnel;
- name of agency or department;
- name and phone number of the agency point-of-contact authorizing access;
- address of agency, vendor or contractor; and
- purpose and level of access.

HHSC management must review the AAL monthly or upon potential indication of an event such as a security breach or personnel change. HHSC management must maintain an authorized personnel list of all staff who have access to information systems areas containing FTI.

C-1052.4 Access Control Systems

Revision 26-1; Effective Jan.1, 2026

All Programs

Access control systems must maintain access control logs with successful and failed access attempts to secured-areas that have Federal tax information (FTI) or systems that process FTI. Access control systems include badge readers, smart cards or biometrics that provide the ability to audit access control attempts. Management must review access control logs monthly. Access control logs must have the following information for each access request:

- the name of the access control device owner;
- the success or failure of the access request; and
- the date and time of the access request.

Transmission Control

Facilities that house systems that process FTI must have security safeguards for transmission controls in place. Safeguards prevent system disruption and tampering. Agency must ensure wiring closets are locked and secure and cables lines must use conduit or cable trays.

Output Device Control

HHSC staff accessing FTI must take precautions to prevent unauthorized people from getting access to output devices used to access FTI. Monitors, printers, headphones, scanners or fax machines used by authorized FTI personnel must be stored in a secure area with need-to-know access.

Store all monitors, printers, headphones, scanners or fax machines used by authorized FTI personnel in a secure area with need-to-know access. Lock all output devices used for accessing or holding FTI when not in use. Key or combination locking mechanisms may secure FTI. Staff not authorized to access FTI may have a key to the building but not the secured room. This includes unauthorized agency staff, contractors, security personnel, custodial staff and landlords.

The following rules apply to FTI related output devices:

- Never print, save or store Automated System for Office of Inspector General-generated FTI documents or commingle any FTI related paper documents in other agency case records.
- Only authorized staff can access the secured-area.
- FTI received by the agency through various output devices must be secured and disposed of per the IRS safeguarding procedures.
- All FTI related output devices must be returned to IT for sanitation before departure for staff who retire, terminate employment or transfer to another position per safeguard guidelines.
- Do not:
  - save FTI documents on agency workstations or OneDrive;
  - send FTI through email; and
  - discuss FTI by phone, Microsoft Teams or any other Office 365 collaboration tool.
- FTI output devices are only used by authorized staff.

Management must ensure FTI output devices are sanitized upon departure of staff that retire, terminate employment or transfer to another position.

Controlling Delivery and Removal of Information System Components

- Authorization and Control
  - Use Form H1861, Federal Tax Information Record Keeping and Destruction Log to track all information system components entering or exiting agency facilities that can receive, store, process or transmit FTI. This information must remain with authorized agency personnel.
  - Authorized personnel conducting delivery or removal of agency FTI system components must comply with agency security and asset management procedures. They must have a documented business need on file.
  - Authorized personnel must verify system components meet agency security standards, including encryption and access control requirements, before deployment or removal.

- Recordkeeping
  - HHSC staff maintain comprehensive records using Form H1861 of all authorized deliveries and removals of system components involving FTI.
  - Records must include:
    - asset identification number;
    - description of the component;
    - date and time of delivery or removal;
    - name and title of authorizing official;
    - name of the person performing the action; and
    - purpose of the action.

Note: Records must be maintained for five years.

C-1053.1 In-Person Transport

Revision 24-3; Effective July 1, 2024

All Programs

Staff transporting media containing FTI must always keep it in their possession. Never leave FTI unattended in a public setting. Use Form H1863 when removing FTI from a file and retain the form for five years from the last FTI removal indicated.

For office relocations, ensure plans include the proper protection and accountability of all FTI. Staff must lock FTI in cabinets or sealed packing cartons while in transit. HHSC staff maintain custody of FTI to ensure cabinets or cartons containing FTI are not misplaced or lost in transit.

C-1053.2 Mail or Courier Transport

Revision 24-3; Effective July 1, 2024

All Programs

Double seal all FTI transported through the mail by sealing one envelope within another envelope. On the inner envelope, staff must mark Confidential with some indication that only the designated recipient is authorized to open it. Do not label the outermost envelope as FTI or provide any indication that it contains FTI. Use Form H1862 when mailing all paper documents that contain IRS data. The sender ensures the receiver acknowledges the receipt of the information.

C-1053.3 Fax Transport

Revision 24-3; Effective July 1, 2024

All Programs

Fax machines must be placed in a secure area and staff should refrain from faxing FTI, when possible. There must be trusted staff at both the sending and receiving fax machines. When faxing is required, staff must use Form H1864. The form must accompany all faxed documents that contain IRS data when transferred from one office to another or from an office to a banking institution for verification purposes. The sender ensures the receiver acknowledges the receipt of the information and retains this form for five years.

C-1054 IRS FTI Sanitation

Revision 24-3; Effective July 1, 2024

All Programs

The sanitization process removes FTI from media to ensure the information cannot be retrieved or reconstructed. Examples include but are not limited to digital media found in scanners, copiers, printers, computers, network components, mobile devices, and non-digital media such as paper and microfilm. Staff must use agency-approved software and methods for sanitizing FTI. The following are acceptable sanitization methods:

- **Clearing** protects the confidentiality of information against a robust keyboard attack. Simple deletion of items is not sufficient. Clearing must not allow information to be retrieved by data, disk or file recovery utilities. It must be resistant to keystroke recovery attempts. Overwriting is an example of an acceptable clearing method.
- **Purging** protects the confidentiality of information against a laboratory attack. This type of attack involves using signal processing equipment and specially trained personnel. Examples of acceptable purging methods are degaussing by destabilizing a device's

magnetic field and for ATA drives only executing the firmware Secure Erase command.

HHSC must maintain sanitization records which include the:

- control number, file name and contents, or both for each record;
- total number of records;
- date and method of sanitation; and
- date of sanitization verification.

C-1055 IRS FTI Destruction

Revision 24-3; Effective July 1, 2024

All Programs

The destruction process ensures that media with FTI cannot be reused as originally intended. Examples include but are not limited to disintegration, incineration, pulverizing, shredding and melting. Staff use Form H1861 to record and track the destruction of FTI. If non-HHSC staff destroy FTI, an HHSC employee must witness the destruction. Staff must use the following approved destruction methods for destroying FTI:

- **Incinerators** certified to produce enough heat to burn the entire bundle. If the incinerator cannot burn the entire bundle, separate the pages to ensure all materials are incinerated.
- **Shredders** producing crosscut particles which are a maximum of 1 mm by 5 mm or 0.04 inches by 0.2 inches. If shredding deviates from these specifications, then the FTI must be safeguarded until it reaches the stage where it is rendered unreadable through additional means, such as burning or pulping.
- **Disintegrator or Pulverizer** equipped with a 2.4-mm or 3/32-inch security screen.

HHSC must maintain destruction records which include the:

- date the records were received;
- control number, file name and contents, or both for each record;
- name of the person receiving the records;
- total number of records, if available;
- movement of records from receipt to destruction; and
- date and method of destruction.

C-1060, Reporting IRS FTI Security Incidents

Body

Revision 24-3; Effective July 1, 2024

All Programs

FTI security incidents include loss of control, unauthorized access, unauthorized disclosure or unauthorized inspection. Upon discovering an actual or possible compromise of IRS FTI or an unauthorized inspection or disclosure of IRS FTI, including breaches and security incidents, the person observing or receiving the information must immediately contact the HHSC IRS coordinator within 24 hours of initial discovery. Send a secure email with the subject line, Urgent: FTI Data Incident Report to the HHSC IRS Coordinator Mailbox.

The HHSC IRS Coordinator reports the incident by:

- contacting the office of the appropriate special agent-in-charge, Treasury Inspector General for Tax Administration (TIGTA); and
- following the IRS Office of Safeguards, as directed in Section 10.2 of IRS Publication 1075.

In the event the HHSC IRS coordinator fails to respond by the close of the next business day, staff immediately inform management by sending an email with the subject line, Urgent – Possible Unauthorized Disclosure or Inspection of FTI to HHSC Offices for Information Technology, Privacy Division, Chief Information Security Office and IRS coordinator.

Examples of FTI security incidents include but are not limited to:

- leaving an agency computer or laptop with FTI unlocked and unattended;
- leaving a file cabinet with FTI unlocked;
- allowing contract IT Help Desk support access to an agency device with FTI while the user is accessing ASOIG;
- printing FTI on Xerox Multi-Factor Office Devices;
- allowing unmonitored contractor access to an FTI hardware server;
- discussing FTI on a Voice over Internet Protocol (VoIP) phone with people or other agency employees;
- viewing FTI remotely without approval;

- sending screenshots of FTI data from the ASOIG application;
- screensharing FTI during virtual meetings, which includes meetings conducted through Microsoft Teams, Zoom, Go To Meeting, Webex and Google Meet; and
- stealing or losing laptop computers, removable devices or non-digital media containing FTI.

Related Policy

Reporting Unauthorized Inspection or Disclosure of Social Security Administration-Provided Information, B-1250

C-1061 Penalties for Disclosing FTI

Revision 24-3; Effective July 1, 2024

All Programs

People responsible for the willful unauthorized inspection or disclosure of FTI may be subject to criminal and civil penalties in addition to disciplinary action. Security incidents may also result in temporary or permanent suspension from ASOIG access.

Criminal penalties for willful unauthorized inspection of FTI are:

- a fine up to $1,000; and
- one year in prison, together with the costs of prosecution.

Criminal penalties for willful unauthorized disclosure of FTI are:

- a fine up to $5,000; and
- up to five years in prison, together with the costs of prosecution.

Civil penalties for willful unauthorized inspection or disclosure of FTI are:

- the greater of $1,000 or actual damages for each incident; and
- court costs and attorney fees to the plaintiff.

C-1100, Other/Miscellaneous

C-1110, Medical Information

Body

C-1111 State Medicaid Agencies

Revision 13-3; Effective July 1, 2013

Medical Programs

For links to all State Medicaid Agencies, go to https://www.medicaid.gov/medicaid/by-state/by-state.html.

C-1112 Services Under the Texas Medical Assistance Program

Revision 19-3; Effective July 1, 2019

Medical Programs

Benefits provided through health insuring agent:

- In-patient hospital services*
- Out-patient hospital services*
- Laboratory and x-ray services
- Physician's services
- Podiatrist's services
- Optometric services*
- Ambulance services*
- Family planning services*
- Home health services limited to nurse and home health aide visits*

- Medicare Part A deductible and coinsurance when benefits would otherwise be payable under Medical Assistance and Medicare Part B deductible and coinsurance for assigned claims only
- Chiropractic treatment — limited to Medicare Part B deductible and coinsurance for assigned claims only
- Eyeglasses*
- Rural health clinics*

Services provided through contract or by direct vendor payments from the Health and Human Services Commission (HHSC):

- Nursing care skilled and intermediate care. Skilled care is limited to recipients age 21 and over. Medicare SNF coinsurance.*
- Active treatment for recipients or patients of any age in licensed and approved section of institutions for persons with intellectual disabilities.*
- In-patient hospital care for recipients or patients age 65 and older in contracted mental hospitals and state (tuberculosis) hospitals.*
- Texas Health Steps screening program and limited dental treatment for eligible persons under age 21.
- Prescriptions limited to no more than three covered per month if over 18. Unlimited if 18 and under.
- Prior authorized hearing aid services.*
- Primary home care for recipients age 18 and over.*
- Other medical transportation.

*With limitations — see appropriate provider manuals for details.

The benefits of this program do not extend to:

- Inmates in a public institution. (Recipients in approved medical units in certain contracted institutions are eligible for vendor payments made by HHSC.)
- Special shoes or other supportive devices for the feet or walking aids.
- Services in military medical facilities, Veteran's Administration (VA) facilities, or United States Public Health Service Hospitals.
- Care and treatment related to any condition for which benefits are provided or are available under Workman's Compensation laws.
- Dental care and services except certain oral surgery or that provided under Texas Health Steps.
- Any services or supplies provided in connection with a routine physical examination except family planning services.
- Any care or services payable under Title XVIII (Medicare).
- Any service provided by an immediate relative of the recipient or member of the recipient's household.
- Any services or supplies not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the malformed body member.
- Custodial care.
- Any services provided to the recipient after a utilization review or medical review finding that such services are not medically necessary.
- Any services or supplies that are payable through a third party.
- Any service or supplies not specifically provided by the Texas Medical Assistance Program.

Disclaimer: This list is for convenient reference and does not have the effect of law, regulation or policy. If there is a conflict between this list and law, regulations, and policy, the latter will prevail. If there is a question, use the appropriate provider manuals or filed releases for clarification.

C-1113 Qualified Hospital/Qualified Entity Policy and Procedures for Presumptive Eligibility Determinations

Revision 15-3; Effective July 1, 2015

TA 66, TA 74, TA 75, TA 76, TA 83, TA 86 and TP 42

Presumptive eligibility (PE) provides short-term medical coverage to pregnant women, Medicaid for Breast and Cervical Cancer (MBCC) applicants, children under age 19, parents and caretaker relatives of dependent children under age 19, and former foster care children. PE provides full fee-for-service Medicaid with the exception of pregnant women. Pregnant women receive ambulatory prenatal care only.

Qualified hospitals (QHs) determine PE for all groups except MBCC.

Qualified entities (QEs) determine PE for pregnant women and MBCC applicants. For MBCC applicants, only QEs that are also Texas Department of State Health Services (DSHS) Breast and Cervical Cancer Services contractors can make MBCC PE determinations, following the process outlined in X-100, Application Processing.

C-1113.1 Eligible Groups

Revision 15-3; Effective July 1, 2015

The following groups can receive presumptive eligibility coverage:

- Children:
    1. MA-Children Under 1 Presumptive — TA 74

2. MA-Children 1–5 Presumptive — TA 75
3. MA-Children 6–18 Presumptive — TA 76

- Former Foster Care Children (MA-FFCC Presumptive —TA 83)
- Pregnant Women (MA-Pregnant Women Presumptive — TP 42)
- Parents and Other Caretaker Relatives (MA-Parents and Caretaker Relatives Presumptive — TA 86)

C-1113.2 Household Composition

Revision 15-3; Effective July 1, 2015

The QH/QE uses the non-taxpayer/non-tax dependent rules to determine the household composition.

C-1113.3 Modified Adjusted Gross Income (MAGI) Methodology

Revision 15-4; Effective October 1, 2015

The QH/QE uses a simplified MAGI methodology to determine if an individual meets the income requirements for PE. The income limits for each PE type of assistance are the same as the income limits for the associated regular Medicaid type of assistance. For example, MA-Children Under 1 Presumptive has the same income limit as MA-Children Under 1.

C-1113.4 Verifications

Revision 15-3; Effective July 1, 2015

The individual must attest to being:

- a Texas resident, and
- a United States citizen or an eligible immigrant.

For all other PE criteria, the individual's statement is acceptable verification. Additional forms of verification beyond an individual's statement are not required.

C-1113.5 Medical Effective Dates

Revision 15-4; Effective October 1, 2015

The medical effective date (MED) is the date the QH or QE determines the individual is presumptively eligible for Medicaid. If the individual is presumptively eligible, QH/QE staff give the individual Form H1266, Short-term Medicaid Notice: Approved. It informs the individual when the PE coverage begins and when the PE coverage ends, based on whether the individual applies for regular Medicaid.

Note: An individual is not eligible for PE if they are currently receiving Medicaid, Children's Health Insurance Program (CHIP) or CHIP perinatal.

If the individual does not apply for regular Medicaid, the PE coverage ends the last day of the month after the month of the PE determination (see scenario 1 below).

If the individual submits Form H1205, Texas Streamlined Application, or Form H1010, Texas Works Application for Assistance — Your Texas Benefits, HHSC staff determine whether the individual is eligible for regular Medicaid. If the individual is not eligible for regular Medicaid, the individual's PE coverage ends the date that HHSC determines the individual is ineligible (see scenario 2 below). If the individual is eligible for regular Medicaid, the individual's PE coverage ends when HHSC makes the Medicaid eligibility determination, following cutoff rules.

If an individual is Medicaid-eligible during the application month, the individual receives Medicaid from the first of that month through the PE MED. Regular Medicaid coverage for the ongoing period begins once the PE period ends (see scenarios 3 and 4 below). **Exception:** Since PE for pregnant women provides only limited prenatal services, ongoing Medicaid coverage overlays the PE coverage (see scenario 5 below).

Examples:

PE Scenarios

Scenario	Determination
1. Individual does not apply for regular Medicaid	A child is determined eligible for MA-Children 6–18 Presumptive on February 2. Her mother does not submit an application for regular Medicaid. The child's PE coverage ends on March 31.

Scenario	Determination
2. Individual is ineligible for regular Medicaid	A child is determined eligible for MA-Children Under 1 Presumptive on April 4. Her father submits an application for regular Medicaid on the same date. HHSC determines on April 20 that the child is not eligible for regular Medicaid. Her PE coverage ends on April 20.
3. Individual is eligible for regular Medicaid (HHSC makes eligibility determination before cutoff)	A child is determined eligible for MA-Children 1–5 Presumptive on March 6. His mother submits an application for regular Medicaid on the same date. HHSC determines on March 15 (before cutoff) that the child is eligible for regular Medicaid. His PE coverage ends March 31. He is certified for regular Medicaid effective March 1 to March 5 and April 1 through ongoing.
4. Individual is eligible for regular Medicaid (HHSC makes eligibility determination after cutoff)	A former foster care child is determined eligible for MA-FFCC Presumptive on May 9. He submits an application for regular Medicaid on the same date. HHSC determines on May 22 (after cutoff) that the individual is eligible for regular Medicaid. His PE coverage ends June 30. He is certified for regular Medicaid effective May 1 to May 8 and July 1 through ongoing.
5. Pregnant woman is eligible for regular Medicaid	A woman is determined eligible for MA-Pregnant Women Presumptive on June 4. She submits an application for regular Medicaid on the same date. HHSC determines on June 10 that the woman is eligible for regular Medicaid. Her PE coverage ends on June 30. Regular Medicaid overlays her PE coverage with an effective date of June 1.

C-1113.6 Periods of Presumptive Eligibility

Revision 15-3; Effective July 1, 2015

Pregnant women are allowed one PE period per pregnancy.

For all other PE groups, an individual is allowed no more than one period of PE per two calendar years. **Example:** An individual receives MA-Children 6–18 Presumptive in June 2015. He cannot receive another period of PE until January 2017.

C-1113.7 Three Months Prior Coverage

Revision 15-3; Effective July 1, 2015

Three months prior coverage does not apply to presumptive eligibility. Eligibility for three months prior Medicaid coverage is determined when HHSC eligibility staff make a regular Medicaid determination, if requested.

C-1113.8 Application Processing

Revision 15-4; Effective October 1, 2015

QH/QE staff first must perform a PE portal inquiry to find out if an individual is currently receiving Medicaid, CHIP or CHIP perinatal or if the applicant has received a period of PE within the PE period limit.

QH/QE staff make the PE determination based on information the individual provides about citizenship/immigration status, Texas residency, income and household composition. To determine whether the individual is presumptively eligible, QH/QE staff fill out Form H1265, Presumptive Eligibility (PE) Worksheet, using the information the individual provides.

If the individual is presumptively eligible, QH/QE staff do the following:

- Enter the individual's demographic information and the PE type of assistance for which the individual is eligible into the PE portal. QH/QE staff use the PE portal to conduct limited inquiries and submit PE determinations.
- Give the individual Form H1266, Short-term Medicaid Notice: Approved. QH/QE staff also help the individual complete and submit the regular Medicaid application via YourTexasBenefits.com if the individual wants to apply. **Note:** An individual is not required to submit a regular Medicaid application to receive PE Medicaid.

If the individual is not eligible for PE, QH/QE staff issue Form H1267, Short-term Medicaid Notice: Not Approved, to the individual and tell the individual about the right to apply for regular Medicaid.

C-1113.9 Due Dates and Processing Time Frames

Revision 15-3; Effective July 1, 2015

Within one business day of the PE determination, the QH/QE must submit the PE determination to HHSC through the PE portal.

C-1113.10 How to Become a Qualified Hospital or Qualified Entity

Revision 15-3; Effective July 1, 2015

Hospitals or entities that want to become qualified to make PE determinations must (1) submit to HHSC a notice of intent, (2) sign a Memorandum of Understanding, and (3) complete online training at the PE website at www.TexasPresumptiveEligibility.com.

C-1113.11 Presumptive Eligibility Forms

Revision 15-3; Effective July 1, 2015

Qualified hospital/qualified entity staff use the following forms in the presumptive eligibility process:

- **Form H1265, Presumptive Eligibility (PE) Worksheet**—Completed by the QH/QE and used to determine if an applicant is presumptively eligible.
- **Form H1266, Short-term Medicaid Notice: Approved**-Completed by the QH/QE and given to an individual determined presumptively eligible. This form notifies the individual about PE coverage and lists the eligibility start date and end date, which is based on whether the individual submits an application for regular Medicaid. If an individual needs proof of Medicaid coverage before receiving their Medicaid identification card, the individual can present this form in an HHSC local eligibility determination office, and HHSC staff will provide the individual with Form H1027-A, Medicaid Eligibility Determination.
- **Form H1267, Short-term Medicaid Notice: Not Approved**— Completed by the QH/QE and given to an individual determined ineligible for PE coverage. This form explains the reason for ineligibility and how to apply for regular Medicaid.

Related Policy

Processing Presumptive Eligibility Applications, A-124

C-1114 Guidelines for Providing Retroactive Coverage for Medical Programs

Revision 26-2; Effective April 1, 2026

Medical Programs

Use the applicable income, standard MAGI income disregard and IRS monthly income thresholds charts when determining retroactive eligibility for children and pregnant women.

Federal Poverty Level (FPL)

March 2024 through February 2025

Family Size	133% FPL March 1, 2024 TP 44, 34, TA 76	144% FPL March 1, 2024 TP 48, 33, TA 75	198% FPL March 1, 2024 TP 40, 42, 43, 36, 35, TA 74
1	$1,670	$1,808	$2,485
2	$2,266	$2,453	$3,373
3	$2,862	$3,099	$4,261
4	$3,458	$3,744	$5,148
5	$4,055	$4,390	$6,036
6	$4,651	$5,036	$6,924
7	$5,247	$5,681	$7,812
8	$5,844	$6,327	$8,699
9	$6,440	$6,972	$9,587
10	$7,036	$7,618	$10,475
11	$7,632	$8,264	$11,362
12	$8,229	$8,909	$12,250
13	$8,825	$9,555	$13,137
14	$9,421	$10,200	$14,025
15	$10,018	$10,846	$14,913
For each additional person	$597	$646	$888

Family Size	201% FPL March 1,2024 TA 84	202% FPL March 1,2024 TA 85	204.2% FPL March 1, 2024 TA 41	400% FPL March 1, 2024 TA 77	413% FPL March 1, 2024 TP 70
1	$2,523	$2,536	$2,563	$5,020	$5,184

Family Size	201% FPL March 1,2024 TA 84	202% FPL March 1,2024 TA 85	204.2% FPL March 1, 2024 TA 41	400% FPL March 1, 2024 TA 77	413% FPL March 1, 2024 TP 70
2	$3,424	$3,441	$3,479	$6,814	$7,035
3	$4,325	$4,347	$4,394	$8,607	$8,887
4	$5,226	$5,252	$5,310	$10,400	$10,738
5	$6,128	$6,158	$6,225	$12,194	$12,590
6	$7,029	$7,064	$7,141	$13,987	$14,442
7	$7,930	$7,969	$8,056	$15,780	$16,293
8	$8,831	$8,875	$8,972	$17,574	$18,145
9	$9,732	$9,781	$9,887	$19,367	$19,997
10	$10,663	$10,686	$10,803	$21,160	$21,848
11	$11,534	$11,592	$11,718	$22,954	$23,700
12	$12,436	$12,498	$12,634	$24,747	$25,551
13	$13,337	$13,403	$13,549	$26,540	$27,403
14	$14,238	$14,309	$14,465	$28,344	$29,255
15	$15,139	$15,215	$15,380	$30,127	$31,106
For each additional person	$902	$906	$916	$1,794	$1,852

Five Percentage Points of FPL

Family Size	2024 Monthly Disregard Amount
1	$62.75
2	$85.20
3	$107.60
4	$130.00
5	$152.45
6	$174.85
7	$197.25
8	$219.70
9	$242.10
10	$264.50
11	$286.95
12	$309.35
13	$331.75
14	$354.20
15	$376.60
For each additional person	$22.45

IRS Monthly Income Thresholds

Type of Income	2024 Threshold	Apply Threshold Value in Form H1042, Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP
Unearned Income	$104.17	• Pages 4-6, Step 3, Part 7 • Pages 4-6, Step 3, Part 9
Earned Income	$1,154.17	Pages 4-6, Step 3, Part 8

Federal Poverty Level (FPL)

March 2025 through February 2026

Family Size	133% FPL March 1, 2025 TP 44, 34, TA 76	144% FPL March 1, 2025 TP 48, 33, TA 75	198% FPL March 1, 2025 TP 40, 42, 43, 36, 35, TA 74
1	$1,735	$1,878	$2,583
2	$2,345	$2,538	$3,490
3	$2,954	$3,198	$4,398
4	$3,564	$3,858	$5,305
5	$4,173	$4,518	$6,213
6	$4,783	$5,178	$7,120
7	$5,393	$5,838	$8,028
8	$6,002	$6,498	$8,935
9	$6,612	$7,158	$9,843
10	$7,221	$7,818	$10,750

Family Size	133% FPL March 1, 2025 TP 44, 34, TA 76	144% FPL March 1, 2025 TP 48, 33, TA 75	198% FPL March 1, 2025 TP 40, 42, 43, 36, 35, TA 74
11	$7,831	$8,478	$11,658
12	$8,440	$9,138	$12,565
13	$9,050	$9,798	$13,473
14	$9,660	$10,458	$14,380
15	$10,269	$11,118	$15,288
For each additional person	$610	$660	$908

Family Size	201% FPL March 1, 2025 TA 84	202% FPL March 1, 2025 TA 85	204.2% FPL March 1, 2025 TA 41	400% FPL March 1, 2025 TA 77	413% FPL March 1, 2025 TP 70
1	$2,622	$2,635	$2,664	$5,217	$5,387
2	$3,543	$3,561	$3,600	$7,050	$7,280
3	$4,464	$4,487	$4,535	$8,884	$9,173
4	$5,386	$5,412	$5,471	$10,717	$11,065
5	$6,307	$6,338	$6,407	$12,550	$12,958
6	$7,228	$7,264	$7,343	$14,384	$14,851
7	$8,149	$8,190	$8,279	$16,217	$16,744
8	$9,071	$9,116	$9,215	$18,050	$18,637
9	$9,992	$10,042	$10,151	$19,884	$20,530
10	$10,913	$10,967	$11,087	$21,717	$22,423
11	$11,834	$11,893	$12,023	$23,550	$24,316
12	$12,756	$12,819	$12,959	$25,384	$26,209
13	$13,677	$13,745	$13,895	$27,217	$28,102
14	$14,598	$14,671	$14,831	$29,050	$29,995
15	$15,519	$15,597	$15,766	$30,884	$31,888
For each additional person	$922	$926	$936	$1,834	$1,893

Five Percentage Points of FPL

Family Size	2025 Monthly Disregard Amount
1	$65.25
2	$88.15
3	$111.05
4	$134.00
5	$156.90
6	$179.80
7	$202.75
8	$225.65
9	$248.55
10	$271.50
11	$294.40
12	$317.30
13	$340.25
14	$363.15
15	$386.05
For each additional person	$22.95

IRS Monthly Income Thresholds

Type of Income	2025 Threshold	Apply Threshold Value in Form H1042, Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP
Unearned Income	$108.33	• Page 4-6, Step 3, Part 7 • Page 4-6, Step 3, Part 9
Earned Income	$1,216.67	• Page 4-6, Step 3, Part 8

C-1115 Immunization Terms

Revision 13-3; Effective July 1, 2013

TANF and Medical Programs

Immunization by inoculation or vaccination protects against childhood diseases. Except for tetanus, these diseases are contagious. Encourage individuals to follow the Texas Department of Health's recommended schedule found on Form H1012, Immunization Record. If a child is on an alternate schedule refer to A-2125, Immunizations.

The following are descriptions of the diseases and symptoms associated with immunizations.

- **Diphtheria —** An acute, bacterial illness that causes a sore throat and a fever and sometimes causes more serious or even fatal complications.
- **Haemophilus Influenza Type b (HIB) —** A bacterium that can cause meningitis and pneumonia and infect other body systems such as blood, joints, bones and soft tissue under the skin, throat, and the covering of the heart.
- **Hepatitis A —** An infection of the liver caused by the Hepatitis A virus.
- **Hepatitis B —** An infection of the liver caused by the Hepatitis B virus.
- **Measles —** An acute, highly contagious viral disease involving the respiratory tract that causes a characteristic rash, fever, runny nose, sore eyes, and cough.
- **Mumps —** An acute viral disease mainly of childhood. It is characterized by a swelling of the parotid (salivary) glands on one or both sides and may cause fever, headache, and difficulty swallowing may develop.
- **Pertussis (Whooping Cough) —** An acute highly contagious respiratory disease characterized by a severe attack of coughing that ends in a characteristic "whoop" as breath is drawn in.
- **Poliomyelitis (Polio – once known as "infantile paralysis") —** An infectious disease that may lead to extensive paralysis of the muscles.
- **Rubella (German Measles) —** A viral infection characterized by a mild fever, swollen glands in the neck and a rash that lasts up to three days.
- **Tetanus (Lockjaw) —** A very serious disease of the central nervous system caused by an infection of a wound that makes an individual unable to open his/her mouth or swallow and causes muscle spasms in the jaw, neck, leg or other muscles.
- **Varicella (Chickenpox) —** A highly contagious viral infection which presents as a generalized, itchy, vesicular rash. The rash begins as smooth, red spots which develop into blisters that last three to four days before forming crusty scabs.

C-1116 Managed Care Plans

Revision 19-1; Effective January 1, 2019

Information concerning the medical and dental managed care plans with contact information for each plan is located at https://www.hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/medicaid-medical-dental-policies.

Related Policy

Managed Care, A-821.2
Releasable Information for Medicaid Providers and Their Contractors, B-1230
Office of the Ombudsman,B-1420

C-1118 Health Care Orientation Quick Reference Guide

Revision 24-4; Effective Oct. 1, 2024

TP 43, TP 44, and TP 48

Steps to Verification

Use the following items to verify the person's identity. Review the Expanded Health Care Orientation and Enrollment Script below for verification instructions.

- Address
- Date of birth
- Medicaid ID number or SSN
- Name
- Phone number

- Primary language spoken in the home
- Third-Party resources, such as private insurance

Essential Steps to Education - Quick Reference Guide:

- Introduce yourself by providing your name and position.
- Explain Medicaid program knowledge, including not to pay bills and what Medicaid covers.
- Explain the Your Texas Benefits Medicaid ID card.
- Explain how to maintain eligibility, including reading mail, returning information and receiving checkups.
- Explain the Texas Health Steps program knowledge, including checkup schedules, for children through 20 years. Refer to the Texas Health Steps Desk Reference below for the information that should be covered.
- Explain medical and dental providers can be located by calling your health or dental plan or for immediate help finding a doctor or dentist, call 877-847-8377.
- Explain how to schedule an appointment and how to offer to get help with scheduling, call the toll-free number at 877-847-8377 and get information on keeping and canceling appointments.
- Explain managed care, including how to enroll and select a primary care provider (PCP).
- Explain about PCPs, referrals, specialists and emergency rooms.
- Explain STAR enrollment will be effective in 15 to 45 days and traditional Medicaid is in effect until STAR enrollment.
- Explain they will receive an ID card from the health plan.
- Explain how to make managed care changes, including how to change plans or a primary care provider and how often it is allowed. Provide the contact information necessary to call to make changes.
- Explain case management for children and pregnant women for health risk or health condition and trouble finding services.
- Explain medical transportation is an available benefit and provide the contact information. If needed, the person should call for transportation help.
- Explain CHIP for any uninsured children in the household.
- Explain the Women, Infant, and Children's Program (WIC) is for pregnant women or children in the family who are under 5.
- Ask if the person has any questions or if they would like you to repeat any information, especially any of the contact information given.
- Inform the person they have completed the Health Care Orientation.

Expanded Health Care Orientation Script

Introduction

Standard greeting to include your name, program and purpose for calling. For example: Hello, may I speak with [case name]: Hello, Mr. or Mrs._____. My name is _____ with Texas Health and Human Services. Since your child or children are new to Medicaid, a state law requires that you receive what is known as a Health Care Orientation. This will only take a few minutes and I will give you some valuable information about how to use your child's or children's Medicaid benefits.

Steps to Caller Verification

Use the following questions to verify the caller’s identity.

- Medicaid ID number or SSN - Do you have Your Texas Benefits Medicaid ID card handy? Will you read the number that appears on the card below your child's name?
- Name - What is the name of your child?
- Address – What is your address?
- Primary Language Spoken in Home – What is the preferred language spoken in the home and document the language.
- Phone Number – What is your correct phone number?
- Date of birth – What is the full date of birth for the child?
- Third Party Resources - Private Insurance: Does your child have any private health insurance?

Medicaid Program Knowledge

Tell the family Medicaid pays for you or your child's care when they go to the doctor, if they are in the hospital, if they go to the dentist and if they go to a specialist. It will also pay for prescriptions, vaccines, transportation to any Medicaid covered service, and for behavioral health services. It also pays for Texas Health Steps preventive medical and dental checkups for children through 20. Medicaid only pays providers like doctors, dentists, specialists and hospitals. You should not receive any bills. However, if you receive a bill don't pay it. First call the provider and find out why they did not send the bill to Medicaid. Make sure your provider has the Medicaid ID number needed for billing.

Note: If the recipient is on STAR, direct them to call their health plan. If they are on fee for service, direct them to call the number on the back of the Your Texas Benefits Medicaid ID card for billing questions 800-252-8263.

Your Texas Benefits Medicaid ID Card-Process

Ask the family if they have received their new Your Texas Benefits Medicaid ID card. If not, explain the new card they will receive is good for as long as they are on Medicaid. Describe the Your Texas Benefits Medicaid ID card.

Inform the family that their STAR health plan should be listed on the Your Texas Benefits Medicaid ID card.

Remind the family to take the Your Texas Benefits Medicaid ID card to the doctor, dentist, pharmacy and every time they obtain a Medicaid service.

Explain to the family if they do not receive their Your Texas Benefits Medicaid ID card in the next couple of weeks, they should contact their local HHSC office to confirm eligibility. Once eligibility is confirmed, they can contact the Your Texas Benefits Medicaid ID card Help Desk at 855-827-3748 to check the status of the card order. Inform them they can also print a copy of their card from the YourTexasBenefits.com website while they wait on their permanent card.

Maintaining Eligibility

Tell the family to Follow up with any paperwork you receive from the Texas Health and Human Services Commission (HHSC). HHSC reviews your case from time to time, usually every 12 months. So, it is important to complete the paperwork to keep your child or children on Medicaid.

It is a requirement to receive your Health Care Orientation, which we are providing right now, and for your children to receive their Texas Health Steps preventive checkups to avoid having to go to the office for a face-to-face interview or to be required to return follow-up information at your redetermination.

Texas Health Steps Program Knowledge

If the parent or caretaker is being interviewed for an initial certification including a reapplication after a break in benefits of 60 days or more, the advisor is responsible for initial Texas Health Steps informing, even if the household does not require a Health Care Orientation.

Refer to the Texas Health Steps Desk Reference for the information that must be covered during the Health Care Orientation or when the parent or caretaker must receive just the initial Texas Health Steps informing.

Refer to the Texas Health Steps Program Desk Reference to educate parents and caretakers about when a child's Texas Health Steps medical and dental* checkups are due and issues a health care provider may address during a Texas Health Steps medical or dental checkup. The health care provider will address specific issues for each age and each child.

- **Texas Health Steps Preventive Checkups**: Recipients through age 20 are eligible for preventive medical and dental checkups through Texas Health Steps. Medical checkups may include a health history, physical exam and measurements, screening for vision and hearing, development and behavioral health, nutrition and dental. The dental checkup may include cleaning of teeth, fluoride treatment, sealants and follow up visits.
- **Checkup Schedule:** Texas Health Steps medical checkups are due periodically starting at birth, 1-2 weeks, 2, 4, 6, 9, 12, 15 and 18 months and then once a year based on date of birth. Dental checkups start at 6 months old. Following the first visit, dental checkups are needed every six months.

* Emergency dental services are available at any age and do not require a check on ID.

Texas Health Steps Desk Reference

- If the information is being provided in person, give the family a:
  - Checkups Help Children Stay Healthy! wallet card
  - Don't Miss a Beat brochure
  - Keep Your Child's Checkups in Check brochure
- Advise the family to contact the Texas Health Steps helpline if they would like a medical or dental provider list mailed to them or if they would like immediate help: 877-847-8377, available 8 a.m. - 6 p.m. Central Time, Monday - Friday. The family may also contact their health or dental plan for help locating providers once enrolled.

Steps to Education - Essential Information About Medicaid Health Plans (Managed Care)

1. **Explain Managed Care and Primary Care Provider.** Let me tell you a little about the STAR program. The STAR program is Texas Medicaid Managed Care. Managed care means that you will receive your Medicaid services through a health plan. You only have 30 days from the date you are certified to select a health plan and a primary care provider. The primary care provider can be a doctor, specially trained nurse, clinic or health center. If you don't choose, the STAR program will pick a health plan and primary care provider for you. The primary care provider is available 24 hours a day, 7 days a week to coordinate care for you and your child or children. Have you received an enrollment packet? This is a large white envelope with the different health plan booklets, enrollment form and instructions. Have you already enrolled? If not, I can tell you how to enroll or change your plan if the STAR program picked a plan for you.

   Note: If the person has not yet enrolled, refer them to the enrollment hotline, 800-964-2777.

2. **Explain about primary care providers and emergency rooms.** Your child's primary care provider is the one you contact first when your child or children need any kind of medical health care. Unless it is an emergency, you should contact your primary care provider before you take your child to the emergency room. An emergency would be a problem or condition, including severe pain that is so serious that waiting for routine care might result in serious harm. In an emergency, you may not have time to contact the primary care provider. In that case, call 9-1-1 or take your child to the nearest emergency room.
3. **Explain referrals**: Referrals to specialists for STAR recipients must be obtained through the primary care provider. However, families do not need a referral for the following services: family planning, eye exams and glasses, behavioral health and Texas Health Steps medical or dental checkups. The primary care provider refers your child or children to specialists or hospitals when needed.
4. **Explain the recipients will receive a Your Texas Benefits Medicaid ID card.** After the recipient is enrolled in the STAR program, a Your Texas Benefits Medicaid ID card will be mailed. The recipient will also receive a member ID card from the plan.
5. **Explain limits on making certain changes to STAR** Recipients can change their primary care provider up to four times a year. They can have unlimited changes in their health plan, however, there are time restrictions. Each health plan change can take 15 to 45 days. Call the STAR helpline to change the health plan and call the health plan directly to request a primary care provider change.

Case Management for Children and Pregnant Women

- Explain Case Management for Children and Pregnant Women is a Medicaid benefit. Case managers help families get medical services, school services, medical equipment and supplies, and other services that are medically necessary.
- Case managers can help children and young adults 20 and younger who have a health condition or health risk who are covered by Medicaid. They also can help women of any age with a high-risk pregnancy. The person or family must need help getting services or they must be having trouble finding or connecting with the services that they need related to their health condition or health risk. The family must want the case management services.
- Case managers are either licensed social workers or registered nurses and are trained to help get families the services that they have trouble finding on their own.
- The case manager will meet with the person approved for Medicaid, the person's parent or guardian. They will do a full assessment to find out all the needs a family might have related to the health condition. Then the case manager and family will make a service plan that addresses all the needs.
- Anyone can refer someone for case management services by calling the Texas Health Steps helpline toll-free at 877-847-8377, 8 a.m. - 6 p.m. Central Time, Monday - Friday.

Medical Transportation Service (MTS)

- The MTS provides non-emergency medical transportation (NEMT) services.
- Explain the MTS is available for all Medicaid-covered health care services to those with full Medicaid, not Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB), Children with Special Health Care Needs (CSHCN), and Transportation for Indigent Cancer Patients (TICP), who do not have any other means of transportation.
- Call at least two business days before the appointment in the same county or adjacent county and five business days before an appointment outside the county adjacent to your residence and be prepared to provide your:
    - name;
    - Medicaid ID number;
    - address;
    - phone number;
    - doctor's name and address;
    - doctor's phone number;
    - date; and
    - time of appointment.

Ways to Travel:

- If you don't have a car and you don't have anyone else to drive you, the MTS will help. This may be by bus tickets or by van.
- If you have a car or know someone who can drive you to the appointment, the MTS can pay you or your driver gas reimbursement by the mile.

How do I get a ride? First, set up an appointment with your doctor or provider.

To request a ride, call at least two business days before your appointment, or five business days before the appointment if it is outside your county. Phones are answered Monday - Friday, 8 a.m. - 5 p.m. local time.

You may be able to be approved for same day rides when:

- Your doctor or dentist must see you on the same day.
- You are released from a hospital, clinic, or other health care facility.
- You need a ride to a drugstore.

If you or your child have a Medicaid health plan:

- Call your health plan’s medical transportation contact number.

If you or your child do not have a health plan:

- Call 877-633-8747 (877-MED-TRIP).

Children 14 and younger may not travel without a parent or guardian. Children 15 through 17 may travel without a parent, but the parent must provide written permission before the trip is scheduled.

CHIP

- If anyone in the household is under 19 and does not have health insurance, explain they may be eligible for some type of state-funded health insurance. They may call 2-1-1 Option 2 to apply for CHIP and Children's Medicaid or go to the Your Texas Benefits website.

WIC

- Explain WIC is a supplemental nutrition and education program to provide nutritious foods to help women, infants and children improve on their nutrition. "If you are receiving Medicaid, you are income-eligible for WIC, but you will have to complete a nutritional screening to receive benefits."
- If pregnant or a postpartum woman or a child under 5 years lives in the household, give the parent the 800-942-3678 number or the WIC website so they can locate their nearest WIC office.

Summary

- Any questions about Texas Health Steps or Medicaid?
- Inform the person that they have received a Health Care Orientation.
- Verify the person's information, phone number, migrant status, and if any other children are in the household.
- If enrolled, recap enrollment information including the names of the primary care provider and main dentist, if known, and the name of the health plan.
- Provide toll free number from the Resource Directory for future help and thank the person for their time.
- If in person, provide literature and any numbers needed from the Resource Directory.

Resource Directory

Resource List	Toll Free Numbers	TTY LINE
2-1-1-Texas Information and Referral for other types of community resources	2-1-1, Option 1	2-1-1, Option 1
Billing Questions Hotline for Traditional Medicaid, also known as fee-for-service	800-335-8957	800-735-2988
Health and Human Services Commission (HHSC)	512-424-6500	512-424-6597
Medicaid Hotline Number	800-252-8263	800-735-2988
Medical Transportation Service (MTS)	If you or your child have a Medicaid health plan: Call your health plan's medical transportation contact number. If you or your child do not have a health plan: Call: 877-633-8747 (877-MED-TRIP)	800-735-2988
Social Security Administration (for Medicare and SSI Medicaid)	800-772-1213	800-325-0778
STAR, STAR+PLUS and STAR Kids/STAR Health Help Line	800-964-2777	800-735-2988
HHS Ombudsman Managed Care Assistance Team	866-566-8989	7-1-1
Texas Health Steps	877-847-8377	800-735-2988
HHSC Case Management for Children and Pregnant Women information and referral assistance	If you or your child have a Medicaid health plan, call your health plan. If you or your child do not have a health plan: 877-847-8377	800-735-2988
Children's Health Insurance Program (CHIP)	877-543-7669	800-735-2988

Resource List	Toll Free Numbers	TTY LINE
Women, Infants and Children (WIC)	800-942-3678	800-735-2988

C-1120, IRS Tax Code

Body

Revision 15-4; Effective October 1, 2015

Unauthorized disclosure or unauthorized inspection of an applicant or client's federal tax information by HHSC staff is punishable by law, including but not limited to:

- felony charges,
- imprisonment,
- fines,
- employment dismissal, or
- civil charges.

See United States Code (U.S.C.), Title 26, §7213; 26 U.S.C. §7213A; and 26 U.S.C. §7431 for a complete list of penalties for the unauthorized disclosure or inspection of this information.

C-1130, Reserved for Future Use

Body

Revision 21-3; Effective July 1, 2021

C-1140, TANF and SNAP Overpayment Determination Chart

Body

C—1141 Timely Reported

Revision 13-3; Effective July 1, 2013

TANF and SNAP

When the individual reports a change timely (i.e., individual reported within 10 days of knowing of the change), use B-600, Changes, B-752.1.2, Errors After Certification, and the following chart to determine the first month of overpayment.

If the household reported the change...	then the first month of potential overpayment is...
January 1-8	February
January 9-31	March
February 1-5	March
February 6-28 (or 29th)	April
March 1-8	April
March 9-31	May
April 1-7	May
April 8-30	June
May 1-8	June
May 9-31	July
June 1-7	July
June 8-30	August
July 1-8	August
July 9-31	September
August 1-8	September
August 9-31	October
September 1-7	October
September 8-30	November
October 1-8	November
October 9-31	December

If the household reported the change...	then the first month of potential overpayment is...
November 1-7	December
November 8-30	January
December 1-8	January
December 9-31	February

Note: The first month of overpayment can be no later than two months from the month the change occurred.

C—1142 Untimely Reported

Revision 13-3; Effective July 1, 2013

TANF and SNAP

When the individual fails to report a change timely (i.e., does not report a change later discovered by HHSC or untimely reports a change), use B-600, Changes, B-752.1.2, Errors After Certification, and the following chart to determine the first month of overpayment.

If the change occurred...	then the first month of potential overpayment is...
January 1-31	March
February 1-28 (29)	April
March 1-31	May
April 1-30	June
May 1-31	July
June 1-30	August
July 1-31	September
August 1-31	October
September 1-30	November
October 1-31	December
November 1-30	January
December 1-31	February

Note: The first month of overpayment can be no later than two months from the month the change occurred.

C-1150, Type Programs (TP) and Type Assistance (TA)

Body

Revision 22-3; Effective July 1, 2022

SNAP, TANF and Medical Programs/Assistance

SNAP

Code	Description	Long Description
TA 51	SNAP-CAP/FS-CAP	Supplemental Nutrition Assistance Program Combined Application Project
TA 53	TSAP/FS-TSAP	Texas Simplified Application Project for SNAP Food Benefits
TP 06	SNAP (PA)/FS-PA	Supplemental Nutrition Assistance Program Public Assistance
TP 09	SNAP/FS-NPA	Supplemental Nutrition Assistance Program

TANF

Code	Description	Long Description
TP 01	TANF Basic	Cash assistance for caretakers and deprived children with income below TANF recognizable needs
TP 60	One-Time TANF for Relatives	Once in a lifetime TANF payment for certain relatives who are the caretaker or payee of a related dependent child certified for TANF
TP 61	TANF State Program	Cash assistance for two-parent household with income below TANF recognizable needs

Code	Description	Long Description
TP 71	OTTANF – 1 Adult	One-Time TANF (OTTANF) payment for households with one parent
TP 72	OTTANF – 2 Parents	OTTANF payment for households with two parents

Medical Programs/Assistance — Texas Works

Code	Description	Long Description
TA 31	MA – Parents and Caretaker Relatives – Emergency	Medicaid for an emergency condition for parents and caretaker relatives who do not meet alien status requirements and are caring for a dependent child who receives Medicaid
TA 41	Health Care – Healthy Texas Women	Healthy Texas Women (HTW) for women 15–44 with income at or below the applicable income limit
TA 66	MA – MBCC – Presumptive	Medicaid for Breast and Cervical Cancer – Presumptive
TA 67	MA – MBCC	Medicaid for Breast and Cervical Cancer
TA 74	MA – Children Under 1 Presumptive	Short-term Medicaid for children under 1 with income at or below the applicable income limit
TA 75	MA – Children 1–5 Presumptive	Short-term Medicaid for children 1–5 with income at or below the applicable income limit
TA 76	MA – Children 6–18 Presumptive	Short-term Medicaid for children 6–18 with income at or below the applicable income limit
TA 77	Health Care – FFCHE	Health Care for Former Foster Care in Higher Education with income at or below the applicable income limit
TA 82	MA – Former Foster Care Children	Medicaid for former foster care children 18–25
TA 83	MA – FFCC Presumptive	Short-term Medicaid for former foster care children 18–25
TA 84	CI – CHIP	The Children's Health Insurance Program (CHIP) is health care coverage for children under 19 who are ineligible for Medicaid due to income and who have income at or below the applicable income limit
TA 85	CI – CHIP perinatal	CHIP perinatal is health care coverage for unborn children whose mother is ineligible for Medicaid or CHIP due to income or immigration status and whose income is at or below the applicable income limit
TA 86	MA – Parents and Caretaker Relatives Presumptive	Short-term Medicaid for parents and caretaker relatives caring for a dependent child
TP 07	MA – Earnings Transitional	Twelve months of transitional Medicaid resulting from an increase in earnings
TP 08	MA – Parents and Caretaker Relatives	Medicaid for parents and caretaker relatives caring for a dependent child with income at or below the applicable income limit
TP 20	MA Alimony/Spousal Support Transitional	Up to four months of post Medicaid resulting from an increase in alimony or spousal support
TP 32	MA – MN w/Spend Down – Emergency	Medicaid for an emergency condition for children or pregnant women who do not meet alien status requirements and who are ineligible for any other type of Medicaid, but who have medical expenses that spend down their income to below the Medically Needy Income Limit (MNIL)
TP 33	MA – Children 1–5 – Emergency	Medicaid for an emergency condition for children 1–5 who do not meet alien status requirements and who have income at or below the applicable income limit
TP 34	MA – Children 6–18 – Emergency	Medicaid for an emergency condition for children 6–18 who do not meet alien status requirements and who have income at or below the applicable income limit
TP 35	MA – Children Under 1 – Emergency	Medicaid for an emergency condition for children under 1 who do not meet alien status requirements and who have income at or below the applicable income limit
TP 36	MA – Pregnant Women – Emergency	Medicaid for an emergency condition for pregnant women who do not meet alien status requirements and who have income at or below the applicable income limit
TP 40	MA – Pregnant Women	Medicaid for pregnant woman with income at or below the applicable income limit
TP 42	MA – Pregnant Women Presumptive	Short-term Medicaid for pregnant women with income at or below the applicable income limit
TP 43	MA – Children Under 1	Medicaid for children under 1 with income at or below the applicable income limit
TP 44	MA – Children 6–18	Medicaid for children 6–18 with income at or below the applicable income limit
TP 45	MA – Newborn Children	Medicaid for children through 1 who are born to a Medicaid-eligible mother
TP 48	MA – Children 1–5	Medicaid for children 1–5 with income at or below the applicable income limit
TP 56	MA – MN w/Spend Down	Medicaid for children or pregnant women who are ineligible for any other type of Medicaid, but who have medical expenses that spend down their income to below the MNIL

Code	Description	Long Description
TP 70	Medicaid for the Transitioning Foster Care Youth	Medicaid for Transitioning Foster Care Youth people with income at or below the applicable income limit
TPAL	MA – Historical FMA – Emergency	N/A
TPDE	MA – Deceased Prior Medical	Medicaid for a deceased person
TPPM	MA/ME – Historical Prior Medical	Three months of prior Medicaid – not currently eligible
TP 52	MA – State Foster Care – A	Medicaid
TP 53	MA – State Foster Care – B	Medicaid
TP 54	MA – State Foster Care – 32	Medicaid
TP 57	MA – State Foster Care – D	Medicaid
TP 58	MA – State Foster Care – JPC	Medicaid
TA 78	PCA Medicaid – Federal Match – No Cash	Permanency Care Assistance (PCA) Medicaid – Federal Match – No Cash
TA 79	PCA Medicaid – No Federal Match – No Cash	PCA Medicaid – No Federal Match – No Cash
TA 80	PCA Medicaid – Federal Match – With Cash	PCA Medicaid – Federal Match – With Cash
TA 81	PCA Medicaid – No Federal Match – With Cash	PCA Medicaid – No Federal Match – With Cash
TP 88	MA – Non-AFDC Foster Care – JPC	Medicaid
TP 90	MA – State Foster Care	Medicaid
TP 91	Adoption Assistance – Federal Match – No Cash	Adoption Assistance – Federal Match – No Cash
TP 92	Adoption Assistance – Federal Match – With Cash	Adoption Assistance – Federal Match – With Cash
TP 93	Foster Care – Federal Match – No Cash	Foster Care – Federal Match – No Cash
TP 94	Foster Care – Federal Match – With Cash	Foster Care – Federal Match – With Cash
TP 95	Adoption Assistance – No Federal Match – No Cash	Adoption Assistance – No Federal Match – No Cash
TP 96	Adoption Assistance – No Federal Match – With Cash	Adoption Assistance – No Federal Match – With Cash
TP 97	Foster Care – No Federal Match – No Cash	Foster Care – No Federal Match – No Cash
TP 98	Foster Care – No Federal Match – With Cash	Foster Care – No Federal Match – With Cash
TP 99	MA – Non-AFDC Foster Care	Medicaid
TPAS	MA – Historical Adoption Subsidy	Medicaid

Medical Programs/Assistance — Medicaid for the Elderly and People with Disabilities

Code	Description	Long Description
TA 02	ME – SSI Waivers	SSI Recipient Waivers
TA 03	ME – Manual SSI Waivers	Manual SSI Waivers
TA 04	ME – Manual SSI State Group Home	Manual SSI Recipient State Community-based Group Homes
TA 05	ME – Manual SSI Non-State Group Home	Manual SSI Recipient Non-State Community-based Group Homes

Code	Description	Long Description
TA 06	ME – Manual SSI Nursing Facility	Medicaid for Nursing Facility Resident
TA 07	ME – Manual SSI State Hospital	Medicaid for State Hospital Resident
TA 08	ME – SSI State Group Home	SSI Recipient State Community Based Group Home
TA 09	ME – Manual SSI State Supported Living Center	Medicaid for State Supported Living Center Resident
TA 10	ME – Waivers	Home and Community-Based (HCBS) Medicaid
TA 12	ME – State Group Home	Medicaid for ICF/IID Resident
TA 22	ME – Manual SSI	Manually certified SSI — processed by SSA
TA 26	ME – SSI Non-State Group Home	SSI Non-State Community-based Group Homes
TA 27	ME – Prior Medicaid Institutional/Waiver	Prior Medicaid for person applying for Institutional or Waiver Medicaid
TA 88	ME – Medicaid Buy-In for Children	Medicaid benefits to eligible children with disabilities who are not eligible for Supplemental Security Income (SSI) for reasons other than disability. Individuals must pay a share of the Medicaid premium
TP 03	ME – Pickle	RSDI COLA Disregard Programs — considered eligible based on the 1977 Pickle Amendment
TP 10	ME – State Supported Living Center	Medicaid for State Support Living Center Resident
TP 11	ME – SSI Prior	SSI, two or three months prior, as appropriate
TP 13	ME – SSI	SSI (processed by SSA)
TP 14	ME – Community Attendant	Community Attendant Services
TP 15	ME – Non-State Group Home	Medicaid for ICF/IID Resident
TP 16	ME – State Hospital	Medicaid for State Hospital Resident
TP 17	ME – Nursing Facility	Medicaid for Nursing Facility Resident
TP 18	ME – Disabled Adult Child	Adult children who are at least 18 who have a disability and who were denied SSI due to an entitlement to or an increase in their RSDI Disabled Adult Child (DAC) benefits and who are eligible for Medicaid to ensure continued coverage
TP 21	ME – Disabled Widow(er)	Widows, widowers or surviving divorced spouses who are at least 50 and less than 60 with a disability and who are ineligible for Medicare and were denied SSI due to an increase in their RSDI widow/widower benefits. They are eligible for Medicaid under TP 21 until they reach age 60 or become eligible for Medicare, whichever occurs first
TP 22	ME – Early Aged Widow(er)	Early age widows, widowers or surviving divorced spouses who are 50–65 and ineligible for Medicare and who were denied SSI due to an increase in their RSDI widow/widower benefits. They are eligible for Medicaid under TP 22 until they reach 65 or become eligible for Medicare, whichever occurs first
TP 23	MC – SLMB	Medicare Savings Program — Specified Low-Income Medicare Benefits
TP 24	MC – QMB	Medicare Savings Program — Qualified Medicare Beneficiary
TP 25	MC – QDWI	Qualified Disabled and Working Individuals — A special Medicare savings program that pays Part A Medicare premiums for certain working people under 65 who have a disability and are no longer eligible for free Medicare Part A because of earnings
TP 26	MC – QI 1	Medicare savings program — Qualified people
TP 30	ME – A and D Emergency	Emergency Medicaid for a nonqualified alien
TP 38	ME – SSI Nursing Facility	Medicaid for Nursing Facility Resident

Code	Description	Long Description
TP 39	ME – SSI State Hospital	Medicaid for State Hospital Resident
TP 46	ME – SSI State Supported Living Center	Medicaid for State Supported Living Center Residents
TP 87	ME – Medicaid Buy In	Working people with disabilities who pay a share of the Medicaid premium to be eligible for Medicaid
TA 88	ME-MBIC	A Medicaid program for children with disabilities up to 19 - years old with family income up to 300 percent of the federal poverty level (FPL).

C-1200, Reserved for Future Use

C-1300, Reserved for Future Use

C-1400, Reference

C-1410, Legal Aid

Body

Revision 13-3; Effective July 1, 2013

All Programs

Staff are required to include the address and phone number of legal services available in the area on individual notices.

C-1420, SSA Claim Number Suffixes

Body

Revision 21-2; Effective April 1, 2021

A	Primary Claimant
B	Wife, 62 or over (1st claimant)
B1	Husband, 62 or over (1st claimant)
B2	Young wife with a child in her care (1st claimant)
B3	Wife, 62 or over (2nd claimant)
B4	Husband, 62 or over (2nd claimant)
B5	Young wife with a child in her care (2nd claimant)
B6	Divorced wife, 62 or over (1st claimant)
B7	Young wife with a child in her care (3rd claimant)
B8	Wife, 62 or over (3rd claimant)
B9	Divorced wife, 62 or over (2nd claimant)
BA	Wife, 62 or over (4th claimant)
BD	Wife, 62 or over (5th claimant)
BG	Husband, 62 or over (3rd claimant)
BH	Husband, 62 or over (4th claimant)
BJ	Husband, 62 or over (5th claimant)
BK	Young wife with a child in her care (4th claimant)
BL	Young wife with a child in her care (5th claimant)
BN	Divorced wife, 62 or over (3rd claimant)
BP	Divorced wife, 62 or over (4th claimant)
BQ	Divorced wife, 62 or over (5th claimant)
BR	Divorced husband, 62 or over (1st claimant)
BT	Divorced husband, 62 or over (2nd claimant)
BW	Young husband with a child in his care (2nd claimant)
BY	Young husband with a child in his care (1st claimant)

C1-C9*	Child (minor, disabled or student)
CA-CK	Child (minor, disabled or student) CA = C11, CB = C12, etc.
D	Widow, 60 or over (1st claimant)
D1	Widower, 60 or over (1st claimant)
D2	Widow, 60 or over (2nd claimant)
D3	Widower, 60 or over (2nd claimant)
D4	Widow (remarried after turning 60) (1st claimant)
D5	Widower (remarried after turning 60) (1st claimant)
D6	Surviving divorced wife, 60 or over (1st claimant)
D7	Surviving divorced wife, 60 or over (2nd claimant)
DB	Widow, age 60 or over (3rd claimant)
D9	Widow (remarried after turning 60) (2nd claimant)
DA	Widow (remarried after turning 60) (3rd claimant)
DC	Surviving divorced husband, 60 or over (1st claimant)
DD	Widow, 60 or over (4th claimant)
DG	Widow, 60 or over (5th claimant)
DH	Widower, 60 or over (3rd claimant)
DJ	Widower, 60 or over (4th claimant)
DK	Widower, 60 or over (5th claimant)
DL	Widow (remarried after turning 60) (4th claimant)
DM	Surviving divorced husband, 60 or over (2nd claimant)
DN	Widow (remarried after turning 60) (5th claimant)
DP	Widower (remarried after turning 60) (2nd claimant)
DQ	Widower (remarried after turning 60) (3rd claimant)
DR	Widower (remarried after turning 60) (4th claimant)
DS	Surviving divorced husband, 60 or over (3rd claimant)
DT	Widower (remarried after turning 60) (5th claimant)
DV	Surviving divorced wife, 60 or over (3rd claimant)
DW	Surviving divorced wife, 60 or over (4th claimant)
DX	Surviving divorced husband, 60 or over (4th claimant)
DY	Surviving divorced wife, 60 or over (5th claimant)
DZ	Surviving divorced husband, 60 or over (5th claimant)
E	Mother (widow) (1st claimant)
E1	Surviving divorced mother (1st claimant)
E2	Mother (widow) (2nd claimant)
E3	Surviving divorced mother (2nd claimant)
E4	Father (widower) (1st claimant)
E5	Surviving divorced father (1st claimant)
E6	Father (widower) (2nd claimant)
E7	Mother (widow) (3rd claimant)
E8	Mother (widow) (4th claimant)
E9	Surviving divorced father (2nd claimant)
EA	Mother (widow) (5th claimant)
EB	Surviving divorced mother (3rd claimant)
EC	Surviving divorced mother (4th claimant)
ED	Surviving divorced mother (5th claimant)
EF	Father (widower) (3rd claimant)
EG	Father (widower) (4th claimant)
EH	Father (widower) (5th claimant)
EJ	Surviving divorced father (3rd claimant)
EK	Surviving divorced father (4th claimant)
EM	Surviving divorced father (5th claimant)
F1	Father
F2	Mother
F3	Stepfather
F4	Stepmother

F5	Adopting father
F6	Adopting mother
F7	Second alleged father
F8	Second alleged mother
G1 – G9	Claimants of lump-sum death payments
J1	Primary PROUTY entitled to HIB (less than 3 Q.C.) (General Fund) **
J2	Primary PROUTY entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
J3	Primary PROUTY not entitled to HIB (less than 3 Q.C.) (General Fund)
J4	Primary PROUTY not entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
K1	PROUTY wife entitled to HIB (less than 3 Q.C.) (General Fund)
K2	PROUTY wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
K3	PROUTY wife not entitled to HIB (less than 3 Q.C.) (General Fund)
K4	PROUTY wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
K5	PROUTY wife entitled to HIB (less than 3 Q.C.) (2nd claimant) (General Fund)
K6	PROUTY wife entitled to HIB (over 2 Q.C.) (2nd claimant) (RSI Trust Fund)
K7	PROUTY wife not entitled to HIB (less than 3 Q.C.) (2nd claimant) (General Fund)
K8	PROUTY wife not entitled to HIB (over 2 Q.C.) (2nd claimant) (RSI Trust Fund)
K9	PROUTY wife entitled to HIB (less than 3 Q.C.) (3rd claimant) (General Fund)
KA	PROUTY wife entitled to HIB (over 2 Q.C.) (3rd claimant) (RSI Trust Fund)
KB	PROUTY wife not entitled to HIB (less than 3 Q.C.) (3rd claimant) (General Fund)
KC	PROUTY wife not entitled to HIB (over 2 Q.C.) (3rd claimant) (RSI Trust Fund)
KD	PROUTY wife entitled to HIB (less than 3 Q.C.) (4th claimant) (General Fund)
KE	PROUTY wife entitled to HIB (over 2 Q.C.) (4th claimant) (RSI Trust Fund)
KF	PROUTY wife not entitled to HIB (less than 3 Q.C.) (4th claimant) (General Fund)
KG	PROUTY wife not entitled to HIB (over 2 Q.C.) (4th claimant) (RSI Trust Fund)
KH	PROUTY wife entitled to HIB (less than 3 Q.C.) (5th claimant) (General Fund)
KJ	PROUTY wife entitled to HIB (over 2 Q.C.) (5th claimant) (RSI Trust Fund)
KL	PROUTY wife not entitled to HIB (less than 3 Q.C.) (5th claimant) (General Fund
KM	PROUTY wife not entitled to HIB (over 2 Q.C.) (5th claimant) (RSI Trust Fund)
LM	Black lung miner (1st claimant)
LW	Black lung miner's widow (1st claimant)
M	Beneficiary not entitled to Title II or monthly benefits (Not qualified for automatic free Part A – HIB)
M1	Similar to M, but qualified for automatic free Part A – HIB, but elects to file for Part B – SMIB only
T	• Fully insured beneficiaries who have elected entitlement only to HIB (usually but not always along with SMIB) • End Stage Renal Disease (ESRD) filing for Medicare only • Deemed insured (hospital insurance only)
T2-T9	Multiple eligible children (Medicare Qualified Government Employment (MQGE)) childhood disability benefits)
TA	MQGE primary beneficiary
TB	MQGE aged spouse (1st claimant) spouse
TC	MQGE childhood disability benefits (1st claimant)
TD	MQGE aged widow or widower (1st claimant)
TF	MQGE father
TG, TH, TJ, TK	Multiple eligible MQGE aged spouses
TL, TM, TN, TP	Multiple eligible MQGE aged widow(er)s
TQ	MQGE mother
TE, TR, TS, TT, TU	Multiple eligible MQGE young widow(ers)
TV, TW, TX, TY, TZ	Multiple eligible MQGE disabled widow(er)s
W	Disabled widow, 50 or over (1st claimant)
W1	Disabled widower, 50 or over (1st claimant)
W2	Disabled widow, 50 or over (2nd claimant)
W3	Disabled widower, 50 or over (2nd claimant)

W4	Disabled widow, 50 or over (3rd claimant)
W5	Disabled widower, 50 or over (3rd claimant)
W6	Disabled surviving divorced wife (1st claimant)
W7	Disabled surviving divorced wife (2nd claimant)
W8	Disabled surviving divorced wife (3rd claimant)
W9	Disabled widow, 50 or over (4th claimant)
WB	Disabled widower, 50 or over (4th claimant)
WC	Disabled surviving divorced wife (4th claimant)
WF	Disabled widow, 50 or over (5th claimant)
WG	Disabled widower, 50 or over (5th claimant)
WJ	Disabled surviving divorced wife (5th claimant)
WR	Disabled surviving divorced husband (1st claimant)
WT	Disabled surviving divorced husband (2nd claimant)

* Youngest child is assigned suffix "1." When there are more than nine children in an Eligibility Determination Group (EDG), the 10th child is coded with an A rather than 10, the 11th child is coded with a B, etc.

** Quarters of covered employment.

C-1430, SNAP Allotment Charts

Body

C-1431 Whole Monthly Allotments by Household Size

Revision 25-4; Effective Oct. 1, 2025

SNAP Allotment Chart (PDF)

The shaded portions on the table in this section show monthly, not prorated allotments available to categorically eligible households. This can be $1 or more.

The minimum monthly, not prorated Supplemental Nutrition Assistance Program (SNAP) allotment for a one-or two-person household is $24.

Related Policy

How to Determine Monthly SNAP Allotments, C-122

C-1432 Prorated SNAP Allotments by Application Date

Revision 19-1; Effective January 1, 2019

Prorated Food Snap Allotments (PDF)

Do not issue prorated benefit allotments of less than $10.

Related Policy

How to Determine Monthly SNAP Allotments, C-122
How to Prorate Benefits, C-123
Whole Monthly Allotments by Household Size, A-2321

C-1440, Relationship Charts

Body

C—1441 Guide for Determining Relationship

Revision 13-3; Effective July 1, 2013

TANF and Medical Programs

This guide provides more detailed information about the eligibility requirements for relationship discussed in A-200, Household Composition, and A-520, Relationship. This guide is not all-inclusive.

A When the child no longer lives with the relative listed below ...	B and the child now lives with ...	C can the person listed in Column B be a caretaker/payee for the child?
1. Mother	1. Stepfather	1. Yes
2. Father	2. Stepmother	2. Yes
3. Stepfather	3. Stepfather's Spouse	3. Yes
4. Stepmother	4. Stepmother's Spouse	4. Yes
5. Stepfather's Spouse	5. New Spouse	5. No
6. Stepmother's Spouse	6. New Spouse	6. No
*7. Grandmother	7. Step Grandfather	7. Yes
*8. Grandfather	8. Step Grandmother	8. Yes
*9. Step Grandfather	9. New Spouse	9. No
*10. Step Grandmother	10. New Spouse	10. No
11. Brother	11. Sister-in-law	11. Yes
12. Sister	12. Brother-in-law	12. Yes
13. Brother-in-law	13. New Spouse	13. No
14. Sister-in-law	14. New Spouse	14. No
15. Stepbrother	15. Stepbrother's Spouse	15. Yes
16. Stepbrother's Spouse	16. New Spouse	16. No
17. Stepsister	17. Stepsister's Spouse	17. Yes
18. Stepsister's Spouse	18. New Spouse	18. No
*19. Aunt	19. Aunt's Spouse	19. Yes
*20. Uncle	20. Uncle's Spouse	20. Yes
21. Aunt's Spouse	21. New Spouse	21. No
22. Uncle's Spouse	22. New Spouse	22. No
**23. First Cousin	23. First Cousin's Spouse	23. Yes
**24. First Cousin's Spouse	24. New Spouse	24. No
*25. Niece	25. Niece's Spouse	25. Yes
26. Niece's Spouse	26. New Spouse	26. No
*27. Nephew	27. Nephew's Spouse	27. Yes
28. Nephew's Spouse	28. New Spouse	28. No

*Extends to the degree of "Great-great" for items 19, 20, 25, and 27 and to the degree of "Great-great-great" for items 7, 8, 9 and 10.

**Extends to the first cousin once removed.

C—1442 Guide for Determining Extended Relationships

Revision 06-1; Effective January 1, 2006

Extended Relationships Chart

C-1450, Guidelines for Clearing Quality Control (QC) Findings

Body

C—1451 Dropped – Subject to Review but Not Completed

Revision 20-4; Effective October 1, 2020

All Programs

Form H1025, Report of Quality Control Assessment Findings	Penalty	What to do ...
Not reviewed (reason): Refusal to Cooperate[1]	Yes	Issue Form TF0001, Notice of Case Action, entering the comments for the appropriate program: "Your SNAP or TANF benefits are denied due to your refusal to cooperate with the Quality Control (QC) review. You will incur this penalty through Feb. 2, 20YY, [2] or until you decide to cooperate with the QC review process, whichever occurs first. You will need to contact (insert the QC contact designated by QC State Office) at (insert the QC contact's phone number) to complete the QC review process." Include the Texas Health and Human Services Commission's (HHSC's) Spanish translation: "Sus beneficios de SNAP o TANF se negaron porque usted se negó a cooperar con la revisión de Control de Calidad (QC). Esta sanción se le aplicaráá hasta el 2 de febrero de [Año] o hasta que decida cooperar con el proceso de revisión de la QC, lo que ocurra primero. Para completar el trámite de revisión de la Valoración de Control de Calidad (QC), tiene que comunicarse con (insert the QC contact designated by State Office) al (insert the QC contact's telephone number)." Allow advance notice of adverse action and deny only the EDG for which Form H1025 was received. Do not deny associated EDGs. (See A-2343, Advance Notice.) Call the Texas Integrated Eligibility Redesign System (TIERS) helpdesk before disposing the denied EDG to ensure only the appropriate EDG is denied. **Notes:** • Refusal to cooperate with QC does not affect Medicaid. • The Temporary Assistance for Needy Families (TANF) denial cannot cause SNAP benefits to increase. Do not remove the TANF grant from an associated SNAP budget when denying a TANF EDG for refusal to cooperate with QC. (Refer to policy in A-1324.18, Temporary Assistance for Needy Families (TANF).) When the EDG is denied for any other reason before the time Form H1025 is received (for example, the person failed to return pending information and the EDG is denied effective Sept. 30, the QC review month was September, and Form H1025 is received in October), continue to send Form TF0001 to the household notifying them of the penalty for refusal to cooperate with the QC review..
Not reviewed (reason): Failure to Cooperate[3]	No	Analyze any information provided by QC and adjust the EDG, if necessary.

Notes:

1 Refusal to cooperate indicates the person has refused to cooperate with the QC review process by refusing to provide information or refusing to be interviewed.

2 The penalty period always expires 125 days after the reporting period. The reporting period ends Sept. 30 each year. The penalty period for federal fiscal year (FFY) is October through September of the following year. QC refusal to cooperate penalties expire Feb. 2, 20YY.
Example: The person's sample month is October 2019. The person refuses to cooperate and is penalized. The penalty period expires Feb. 2, 2021 (125 days after Sept. 30, 2020).

3 Failure to cooperate indicates the person has provided all the information and cooperated with the QC review process; however, the QC analyst is unable to complete the review due to an aspect beyond the person's control (for example, the employer or landlord refused to provide information).

C—1452 Dropped – Not Subject to Review

Revision 15-4; Effective October 1, 2015

All Programs

Form H1025, Report of Quality Control Assessment Findings	Penalty	What to do ...
Not reviewed (reason): Moved Out of State	No	If the individual reports in advance of moving, issue Form TF0001, Notice of Case Action, and deny the EDG simultaneously allowing adequate notice. See A-2344.1, Form TF0001 Required (Adequate Notice). Deny the EDG for which Form H1025 was received. When the individual reports after they move out of state or it is determined by QC, deny the EDG following A-2344.2, No Form TF0001 Required. Adjust/deny any other EDGs in which the individual/household members are included.
Not reviewed (reason): Referred to Fraud, Under Active Fraud Investigation or Intentional Program Violation (IPV) EDG	No	No action is required. If, as of the date the EDG is selected for QC sampling, the EDG meets one of the following: • has been referred for investigation to the state's fraud investigation unit, and the investigation is scheduled to begin within five months of sampling; • is under active fraud investigation; or • has a pending administrative or judicial IPV hearing, the IPV EDG is not subject to review.
Not reviewed (reason): Retroactive Benefits	No	No action is required. The sample month benefits were issued retroactively; therefore, the EDG is not subject to review. Example: The file date is November 15 and the certification date is December 15. Benefits for November are issued (retroactively) in December; if November is the sample month, the EDG is not subject to review.
Not reviewed (reason): Unable to Locate	No	When Form H1025 indicates that returned mail has been received by QC, the advisor must send Form TF0001 and deny the EDG simultaneously to allow adequate notice. (See A-2344.1.) When Form H1025 does not indicate that returned mail has been received but that the individual has not been located, advisors must send Form TF0001 to deny for unable to locate allowing advance notice of adverse action. (See A-2343, Advance Notice.) Adjust/deny any other EDGs in which the individual/household members are included.
Not reviewed (reason): All Individuals Who Could Be Interviewed Are Hospitalized, Incarcerated or Placed in a Mental Institution	No	Information discovered by QC is forwarded to the advisor via this format. The advisor needs to analyze the information and adjust the EDG appropriately, including denial. Adjust/deny any other EDGs in which the individual/household members are included.
Not reviewed (reason): EDG Pending a Hearing	No	No action is required.
Not reviewed (reason): Household Did Not Receive Benefits for Sample Month	No	No action is required.

TANF

Form H1025 QC Findings	Penalty	What to do ...
Not reviewed (reason):		Deny the EDG, allow adequate notice and send Form TF0001 simultaneously. Adjust/deny any other EDGs in which the individual/household members are included. (See A-2344.1.)
Death of All Available Adult Household Members	No	The child(ren) may be certified as independent children on appropriate Medicaid EDGs (see A-241.1, Who Is Included) or they may be determined eligible in a new TANF household when all other eligibility requirements are met.
Not reviewed (reason):		
Dormant Electronic Benefit Transfer (EBT) Account	No	No action is required.

SNAP

Form H1025 QC Findings	Penalty	What to do ...
Not reviewed (reason):		
Death of All Household Members	No	Deny the EDG. Adjust/deny any other EDGs in which the individual/household members are included. (See A-2344.2.)
Not reviewed (reason):		
Dormant Account, No Activity in EBT Account, Sample Month and Two Following Months Up To and Including Transmission to Food and Nutrition Services	No	No action is required.

C—1453 Completed QC Reviews

Revision 20-4; Effective October 1, 2020

TANF and SNAP

Form H1025, Report of Quality Control Assessment Findings	Penalty	What to do ...
Completed – Person Refused to Cooperate 1	Yes	Issue Form TF0001, Notice of Case Action, with the following message: "Your SNAP/TANF benefits are denied due to your refusal to cooperate with the Quality Control (QC) review. You will incur this penalty through Feb. 2, 20YY, 2 or until you decide to cooperate with the QC review process, whichever occurs first. You will need to contact (insert the QC contact designated by QC State Office) at (insert the QC contact's phone number) to complete the QC review process." Include HHSC's Spanish translation: "Sus beneficios de SNAP o TANF se negaron porque usted se negó a cooperar con la revisión de Control de Calidad (QC). Esta sanción se le aplicará hasta el 2 de febrero de [YEAR] o hasta que decida cooperar con el proceso de revisión de la QC, lo que ocurra primero. Para completar el trámite de revisión de la Valoración de Control de Calidad (QC), tiene que comunicarse con (insert the QC contact designated by State Office) al (insert the QC contact's telephone number)."

Form H1025, Report of Quality Control Assessment Findings	Penalty	What to do ...
		Allow advance notice of adverse action and deny only the EDG for which Form H1025 was received. Do not deny associated EDGs. (See A-2343, Advance Notice.) **Notes:** • Refusal to cooperate with QC does not affect Medicaid. • The TANF denial cannot cause SNAP benefits to increase. Do not remove the TANF grant from an associated SNAP budget when denying a TANF EDG for refusal to cooperate with QC. (Refer to policy in A-1324.18, Temporary Assistance for Needy Families (TANF).)
Information(al) Only	No	Information discovered by the QC analyst is forwarded to eligibility staff via this form. Eligibility staff need to analyze the information and adjust the EDG appropriately, including denial, if necessary.
Amount Correct:	No	No action is required.

Notes:

1 Refusal to cooperate indicates the person has refused to cooperate with the QC review process by refusing to provide information or refusing to be interviewed.

2 The penalty period always expires 125 days after the reporting period. The reporting period ends Sept. 30th each year. The penalty period for the FFY is October through September of the following year. QC reviews expire Feb. 2, 20YY. **Example:** The person's sample month is March 2020. The person refuses to cooperate and is penalized. The penalty period expires Feb. 2, 2021 (125 days after Sept. 30, 2020).

TANF

Form H1025 QC Findings	Penalty	What to do ...
Underpayment	No	Adjust the EDG accordingly (See B-800, Restored Benefits) and issue supplemental benefits for the current month if the person is currently eligible. **Note:** Consider all reported changes when determining the amount of supplemental or restored benefits. The dollar amount listed is not necessarily the amount of the underpayment. Adjust or deny any other EDGs in which the person or household members are included.
Overpayment	No	Adjust the EDG accordingly and enter the overpayment referral in TIERS. **Note:** Consider all reported changes when determining the amount of the overpayment claim, including changes reported to QC during the exclusionary period and any other information listed by QC as “information only.” The dollar amount listed is not necessarily the amount of the overpayment. Adjust or deny any other EDGs in which the person or household members are included.

SNAP

Form H1025 QC Findings	Penalty	What to do ...
Underissuance	No	Adjust the EDG accordingly. (See B-800, Restored Benefits.) Issue supplemental benefits for the current month if the person is currently eligible. For agency errors only, issue restored benefits for past months regardless of whether the person is currently eligible. Do not restore benefits for unreported changes or household errors. **Note:** Consider all reported changes when determining the amount of supplemental or restored benefits. The dollar amount listed is not necessarily the amount of the underissuance. Adjust or deny any other EDGs in which the person or household members are included.
Overissuance	No	Adjust the EDG accordingly and enter the overissuance referral in TIERS. Refer all SNAP overissuances identified during the QC review process to OIG, regardless of the dollar amount. (See policy in B-720, When to File an Overpayment Referral, prior to sending the referral to OIG.) **Note:** Consider all reported changes when determining the amount of the overissuance claim, including changes reported to QC during the exclusionary period and any other information listed by QC as "information only." The dollar amount listed is not necessarily the amount of the overissuance. Adjust or deny any other EDGs in which the person or household members are included.

C—1454 Reapplying for Benefits after a Quality Control Penalty

Revision 15-4; Effective October 1, 2015

All Programs

When the penalized individual comes in to reapply for benefits after the EDG is closed and the penalty period has ...	and the penalized individual is applying with ...	then the advisor ...
not expired,	the same household composition as was on the EDG reviewed by QC,	checks with the QC State Office staff who issued Form H1025, Report of Quality Control Assessment Findings. If the individual has cooperated with the QC review, the advisor proceeds with the application process. When the individual has not cooperated with the QC review, the advisor denies the application and informs the individual to reapply after they comply with the QC review process. Form TF0001, Notice of Case Action, must include the following: "You will need to contact (insert the QC contact designated by QC State Office) at (insert the QC contact designated by QC State Office) to complete the QC review process." Include HHSC's Spanish translation: "Para completar el trámite de revisión de la Valoración de Control de Calidad (QC), tiene que comunicarse con (insert QC contact designated by State Office) al (insert QC contact designated by State Office)."
not expired,	another household or moved into another household and is a required member of that household,	checks with the QC State Office staff who issued Form H1025. The penalty follows the penalized individual, and the new household is not eligible until the individual complies with QC. When the individual has cooperated with the QC review, the advisor proceeds with the application process. When the individual has not cooperated with the QC review, the advisor denies the application and imposes the disqualification until the individual cooperates or the penalty period expires, whichever comes first, informing the individual to reapply after they comply with the QC review process. Form TF0001 must include the following: "You will need to contact (insert the QC contact designated by QC State Office) at (insert the QC contact designated by QC State Office) to complete the QC review process." Include HHSC's Spanish translation: "Para completar el trámite de

When the penalized individual comes in to reapply for benefits after the EDG is closed and the penalty period has ...	and the penalized individual is applying with ...	then the advisor ...
		revisión de la Valoración de Control de Calidad (QC), tiene que comunicarse con (insert QC contact designated by State Office) al (insert QC contact designated by State Office)".
		Do not disqualify other adults or children who were members of the original penalized household when they apply with or enter another household and the penalized individual(s) is not applying with or entering the new household with them.

C—1455 Frequently Asked Questions

Revision 20-4; Effective October 1, 2020

All Programs

1. **Q: What is the difference between refusal to cooperate and failure to cooperate?**
   "Refusal to cooperate" is a QC response used when the person has refused to cooperate with the QC review process, by refusing to provide information or refusing to be interviewed. "Failure to cooperate" is used when the person has provided all the information and cooperated with the QC review process. However, QC is unable to complete the review because of something beyond the person's control. For example, the person's employer or landlord refused to provide information. A penalty is incurred when the person refuses to cooperate. A penalty is not incurred for failure to cooperate.
2. **Q: How do I know if a penalty has been imposed on a case?**

   The Data Broker Combined Report displays active QC penalties, including the name and phone number of the QC contact designated by QC State Office.

   Additionally, QC maintains a list of sampled cases with imposed penalties. The list can be viewed from the Eligibility Services portal to view the list

   - Enter your user name and password.
   - Select Report Manager.
   - Select QCDW/Case Review List in the Select Report Group.
   - Select the appropriate Drop Case List Report.
   - Enter the criteria for the report.

3. **Q: Are staff required to send Form TF0001 with the appropriate penalty wording for people who are no longer receiving benefits by the time Form H1025, Report of Quality Control Assessment Findings, is received? Example: The EDG is denied in March 2020, and staff receive Form H1025 information June …. 2020. The person is not receiving benefits when Form H1025 is received. The penalty period expires Feb. 2, 2021.**
   Yes. The person must be notified of the penalty period. Form TF0001 must advise the person that the person cannot receive benefits through Feb. 2, 2021, or until the person cooperates with the QC analyst, whichever is earlier as noted in #3 above.
4. **Q: Does the penalty period ever change? If so, how does it change?**
   The penalty period is always 125 days after the reporting period ends. The reporting period ends each federal fiscal year on Sept. 30. One hundred twenty-five days from Sept. 30 is Feb. 2. These are for the prior federal fiscal year.
5. **Q: Do we deny the entire EDG or just the person listed on Form H1025?**
   Deny the entire EDG reviewed by QC. **Note:** When denying a TANF EDG for refusal to cooperate, the associated SNAP benefits should not be increased (the TANF grant should not be removed from the budget) as the person failed to cooperate with a QC review (see A-1324.18, Temporary Assistance for Needy Families [TANF]).
6. **Q: Can the person appeal the denial of the EDG when it has been denied for refusal to cooperate?**
   Yes, the decision may be appealed. (Refer to B-1000, Fair Hearings.)

TANF

1. **Q: Is the person entitled to restored benefits when QC discovers an underpayment?**
   When the household is currently eligible for and receiving TANF, then the answer is yes. (See B-810, Entitlement to Restored Benefits.)
2. **Q: What happens when we restore benefits and the person has an overpayment claim filed?**
   The restored benefits must be used to offset the claim first. (See B-810.)

SNAP

1. **Q: Is the person entitled to restored benefits when QC discovers an underissuance?**
   When the QC error was caused by the agency, then the answer is yes. When the QC error was caused by the person due to unreported changes or other personal errors, no, they are not entitled to restored benefits. (See B-840, Notice to the Household.)
2. **Q: What happens when we restore benefits and the person has an overissuance claim filed?**
   The restored benefits must be used to offset the claim first. (See B-810.)

C-1460, Helpful Toll-Free Numbers

Body

Revision 19-2; Effective April 1, 2019

All Programs

Use the following list of toll-free phone numbers for reference purposes, or print the list and provide it to applicants or recipients.

Question or Concern	Organization	Telephone No.
Questions about social services or community resources in Texas, including the location and phone number of local agency offices.	2-1-1 Texas Information and Referral Network	2-1-1 or 877-541-7905 (after selecting a language, press 1)
Provides households with information about EDG status such as active, on hold or denied; benefit amounts; and availability dates of current benefits.	Automated Voice Response (AVR) system hotline	2-1-1 or 877-541-7905 (after selecting a language, press 2)
Assists the public with issues or complaints about health and human services programs that have not been resolved under the agency's normal complaint process.	Texas Health and Human Services Office of the Ombudsman	877-787-8999
To report suspicions of the abuse or neglect of children, or the abuse, neglect or exploitation of people age 65 or older or adults with disabilities.	Texas Department of Family and Protective Services	800-252-5400
Questions about Social Security Administration benefits or the maintenance of an individual's record.	Social Security Administration	800-772-1213 TTY number 800-325-0778
For claims of discrimination experienced by either individuals or applicants.	HHSC Civil Rights Office	888-388-6332
Concerns about fraud, waste or abuse of SNAP, Medicaid, TANF or Children's Health Insurance Program (CHIP) services or benefits.	Office of Inspector General	800-436-6184
The Children with Special Health Care Needs Services Program, within the Division for Family and Community Health Services, which provides services to children with extraordinary medical needs, disabilities and chronic health conditions.	Texas Department of State Health Services	800-252-8023
For child support services including the collection of court-ordered child support, information about the Crime Victims Compensation Fund and enforcement of the state's consumer protection laws.	Office of Attorney General	800-252-8011
For information on early intervention services for children with disabilities and developmental delays, services for people who are deaf or hard of hearing or children who are blind or visually impaired.	Texas Health and Human Services	Main number: 512-424-6500 TTY number: 512-424-6597
For information on vocational rehabilitation for persons with disabilities, and services for adults who are blind or visually impaired.	Texas Workforce Commission	800-628-5115

Question or Concern	Organization	Telephone No.
For information on disability determination services.	Social Security Administration	800-772-1213 TTY number: 800-325-0778
Information and assistance concerning family violence.	National Domestic Violence 24-hour hot line	800-799-SAFE (7233) TTY number 800-787-3224

Medicaid

Question or Concern	Organization	Telephone Number
Help finding or questions about a doctor, dentist or case manager for a person age 20 or younger.	Texas Health Steps	877-847-8377
For transportation assistance to a doctor's appointment.	Medical Transportation (HHSC)	877-633-8747
Helps people enrolled in STAR, STAR+PLUS, STAR Health or STAR Kids with Medicaid managed care issues.	HHSC Medicaid Managed Care Helpline	866-566-8989
Questions about services covered by Medicaid, or help when a bill is received from a Medicaid provider, or questions about Medically Needy with Spend Down cases.	Statewide Medicaid help line	800-335-8957
Questions about enrolling in the STAR Managed Care Program or help changing a health plan.	State of Texas Access Reform (STAR)	800-964-2777

C-1470, Eligibility Environments

Body

Revision 15-4; Effective October 1, 2015

All Programs

Texas Works serves applicants and recipients in Texas through a variety of eligibility environments. The following is a brief summary of each type.

Local eligibility offices: HHSC staff conduct business in a face-to-face environment with people seeking information or applying for health and human services programs. Interviewing tasks are performed at the local eligibility office either in person or by telephone.

The eligibility staff in local offices provide information and application assistance, receive applications, perform Data Broker and other third-party inquiries, collect data, assess missing information, determine eligibility, issue benefits, and perform other tasks associated with eligibility services operations. Work is processed by eligibility staff in local offices in TIERS. Individuals are assigned to specific offices and a single eligibility worker processes an EDG until it is disposed as approved or denied.

Eligibility staff in a local office process multiple types of assistance: SNAP, Medicaid, CHIP, and TANF. Eligibility staff in the offices work all types of EDGs/cases; however, some offices may have specialized staff based on workload. Clerical staff handle front desk and lobby-area tasks, telephones, mail, faxes, scheduling and other support duties.

Vendor staff creates and routes tasks for applications received via mail or fax to staff in the local eligibility offices or changes received via telephone, mail or fax to staff in the Customer Care Centers (CCCs). The vendor may register a new application or reschedule an appointment, then route the interviewing tasks to local eligibility offices. Applications, redeterminations and changes submitted online through YourTexasBenefits.com are routed to the appropriate areas by the State Portal.

Centralized units: These units are able to specialize in certain programs or tasks and conduct eligibility work through the mail and by telephone without face-to-face contact. The centralized units help balance the workload of local eligibility offices. In a centralized unit, tasks are assigned based on due dates. Centralized functions have centralized mail, centralized telephone systems and do not require lobby space as eligibility offices do. Centers also have staff to answer telephones and provide status information, in addition to the staff working the cases.

C—1471 Specialized and Centralized Casework Units

Revision 22-4; Effective Oct. 1, 2022

The following chart details various specialized and centralized casework units.

Centralized Units That Serve Both Texas Works (TW) Programs and Medicaid for the Elderly and People with Disabilities (MEPD) Programs

Unit Name	Description
Centralized Representation Unit (CRU)	The CRU files appeal requests and assembles EDG information in preparation for hearings for TIERS cases. The CRU represents the agency at fair hearings and implements all decisions for EDGs statewide. Members of this unit are housed across the state in local eligibility offices. HHSC created the unit in September 2007, and the unit initially processed EDG actions resulting from TIERS fair hearings for both Texas Works and MEPD. More details are available in the Eligibility Services State Processes document. Staff must file all appeal requests using the Hearings and Appeal — Create Appeal functionality in TIERS, accessed through the left navigation menu. Form H4800, Fair Hearing Request Summary, which is sent directly to the hearings division, is returned to staff with instructions to enter the information in TIERS.
Customer Care Centers (CCCs)	The CCC office locations are in Athens, Austin, El Paso, Houston, Midland and San Antonio. State staff, along with vendor staff, conduct business using the 2-1-1 Texas phone system. CCC staff handle inquiries and concerns that vendor staff cannot resolve. The vendor creates tasks and routes non-interview changes received by phone, mail, fax or the Self-Service Portal to state staff in the CCCs. The CCCs are supported by TIERS and by eligibility supporting technologies, such as the Task List Manager and the State Portal. CCC state staff perform Data Broker and other third-party inquiries, collect data, assess missing information, determine eligibility, issue benefits, process individual and agency generated changes, perform other non-interview tasks, and process six-month income check task. CCC performs these functions, as applicable, for TW and MEPD. The CCC operates Monday to Friday from 8 a.m. to 6 p.m. Central time (excluding state holidays). Below are some helpful toll-free numbers: • 800-645-7164 — CHIP provider toll-free phone line • 877-543-7669 (877-KIDS-NOW) — CHIP and Children's Medicaid toll-free phone line • 800-735-2988 or 7-1-1 — TDD/TTY users (Relay Texas) Effective Jan. 15, 2013, HHSC centralized the clearance of Income Eligibility and Verification System (IEVS) Internal Revenue Service (IRS) data matches for TW and MEPD. Data matches that OIG identifies for each program are processed by CCC staff. HHSC set up CCCs with the Integrated Eligibility and Enrollment pilot rollout in January 2006.
Assistance Response Team (ART)	ART staff housed throughout the state serve as on-site support to regional staff. These state staff offer TIERS technical support for Texas Works and MEPD on-the-job trainings (OJT), conduct clerical OJTs, offer TIERS technical support to eligibility staff (offer pre-ticket support to all regions to mitigate unneeded tickets), process Texas Works cases based on MEPD email box referrals and Health Insurance Portability and Accountability Act of 1996 (HIPAA) referrals for all regions, and assist State Office Data Integrity (SODI) with merging assignments. HHSC set up ART with the Integrated Eligibility and Enrollment pilot rollout in January 2006.

Centralized Units That Serve Only MEPD Programs

Unit Name	Description
MEPD	HHSC created a special statewide eligibility unit in January 2007 to process eligibility for MEPD programs. Statewide staff specialize in MEPD eligibility programs to help make sure MEPD casework is evenly distributed. Members of this unit are housed across the state in local eligibility offices.

Centralized Units That Serve Only Texas Works Programs

Unit Name	Description
Centralized Benefit Services (CBS)	Staff in this centralized Austin location process SNAP EDGs for households in which all members get Supplemental Security Income (SSI), using specialized automation that supports the modified eligibility requirements for these households. In addition, the unit also processes applications, redeterminations and changes for: • SNAP Combined Application Project (SNAP-CAP) EDGs; • Medicaid for Breast and Cervical Cancer (MBCC);

Unit Name	Description
	• Medicaid for children under the jurisdiction of the juvenile court and for youth under 19 in non-secure facilities; • Medicaid for Transitioning Foster Care Youth (MTFCY); • Former Foster Care Children (FFCC); • Medicaid for inmates of a public institution; and • qualified aliens admitted as refugees. and applications for: • Former Foster Care in Higher Education (FFCHE) health care benefits program. Appointed staff process Medicaid requests for babies born to mothers incarcerated in Texas. Most babies receive ongoing Medicaid, but factors such as with whom the baby will reside or if the baby will remain in Texas may affect eligibility. When the baby cannot be certified for ongoing newborn Medicaid, the EDG is referred to Data Integrity to add coverage for the birth of the baby under a state-paid medical program.
Children's Medicaid Center (CMC)	Centralized CMCs process applications and renewals for Children's Medicaid and CHIP. They do not process other associated-program case actions, to ensure a streamlined, timely approach. The CMC office locations are in regions across the state: • Region 3 (Dallas Metroplex) • Region 6 (Houston) • Region 8 (San Antonio) • Region 11 (Rio Grande Valley) Currently, Regions 3, 6 and 8 have CMCs to process applications and renewals for Children's Medicaid and CHIP for their respective regions.
Healthy Texas Women (HTW)	This center, located in San Antonio, processes statewide HTW applications, changes and renewals. The HTW center also process Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification, for CHIP perinatal mothers.

Part D, Children's Health Insurance Program

D-100, Overview

D-110, General Policy

Body

Revision 26-1; Effective Jan. 1, 2026

CHIP

The Children's Health Insurance Program (CHIP) provides health care coverage for children under 19 whose family income exceeds the Children's Medicaid income limit but is less than or equal to 201% of the federal poverty level (FPL). This is the applicable income limit for TA 84 (CHIP).

Children who do not qualify and remain ineligible for Medicaid are eligible to enroll in CHIP and receive up to 12 months of continuous coverage. Families with net income above 151% of the FPL must pay an enrollment fee. Most families also have copayments for doctor visits, prescription drugs and emergency care.

When an applicant requests children's health coverage, the child is first tested for Medicaid eligibility. If ineligible for Medicaid, the child is then tested for CHIP eligibility. When processing a change for a person certified for CHIP, the eligibility determination system automatically tests the person for Medicaid eligibility. A new application is not required.

CHIP eligibility is prospective. The medical effective date (MED) is based on if the Eligibility Determination Group (EDG) is disposed before or after cutoff and when the enrollment process is completed. The eligibility determination system provides the potential eligibility begin date, and Enrollment Broker provides the actual eligibility begin date.

CHIP Perinatal

CHIP perinatal provides services to unborn children of pregnant women, regardless of age. These pregnant women are ineligible for:

- Medicaid due to income more than 198% of the FPL, the applicable income limit for Medicaid for Pregnant Women (TP 40), but whose household income is at or below 202% of the FPL, the applicable income limit for CHIP Perinatal (TA 85); or
- Medicaid or CHIP due to immigration status if the pregnant woman is not a citizen or qualified alien.

When processing a change for a person certified for CHIP perinatal, the eligibility determination system automatically tests the person for Medicaid eligibility. A new application is not required.

The unborn children of pregnant women eligible for CHIP perinatal are granted 12 months of continuous eligibility from the month the eligibility determination is made. This 12-month period includes the months of CHIP perinatal coverage before and after birth. The mother receives CHIP coverage related to the birth only. She does not receive personal health care coverage.

Because CHIP perinatal only provides coverage for pregnancy-related services, women certified for CHIP perinatal must apply for Emergency Medicaid or Medically Needy (MN) with Spend Down-Emergency to receive coverage for medical conditions not related to their pregnancy.

Receiving CHIP perinatal does not affect the mother's eligibility for:

- MA-Pregnant Women – Emergency (TP 36);
- MA-Parents and Caretaker Relatives Medicaid – Emergency (TA 31);
- MA-MN with Spend Down – Emergency (TP 32); or
- MA-Children 6-18 – Emergency (TP 34).

Pregnant women may receive the programs above in the same month as CHIP perinatal. This is not considered dual coverage. Pregnant women may have concurrent CHIP perinatal and Medicaid for Pregnant Women – Emergency (TP 36) or Medically Needy with Spend Down – Emergency (TP 32) during their pregnancy if certain criteria are met. Follow the chart below to determine if concurrent coverage should be provided.

If	then
an application is received with a report of pregnancy and a Form H3038, Emergency Medical Services Certification, for an emergency event not related to labor and delivery,	• certify TP 36 or TP 32 once the spend down amount is met, effective the date of the emergency event through the 12-month postpartum period; and • certify CHIP perinatal.
an application is received for an active CHIP perinatal recipient with a Form H3038 for an emergency event not related to labor and delivery,	• certify TP 36 or TP 32 once the spend down amount is met, effective the date of the emergency event through the 12-month postpartum period; and • maintain the woman's CHIP perinatal certification period.
an application is received with a report of a new pregnancy or a new pregnancy is reported as a change without an application for a TP 36 recipient in her postpartum period,	• certify CHIP perinatal based on the new pregnancy; and • maintain the woman's existing TP 36 coverage through the initial 12-month postpartum period.

When a child is born to a CHIP perinatal mother whose household income is above the applicable income limit for Medicaid for Pregnant Women, the child's coverage begins on the date of birth and the mother's coverage is terminated on the last day of the month the birth occurs. The mother is eligible for two postpartum visits that may occur after the mother's CHIP perinatal coverage ends. At birth, the child receives perinatal coverage for the remainder of the 12-month eligibility period. The child's CHIP perinatal enrollment is terminated at the end of the 12-month period.

When a child is born to a CHIP perinatal mother whose household income is at or below the applicable income limit for Medicaid for Pregnant Women, and the mother receives Emergency Medicaid to cover the labor with delivery charges, enroll the child in TP 45 effective the child's date of birth. The mother's perinatal coverage ends the last day of the child's birth month or the pregnancy termination month. The mother is eligible for two postpartum visits that may occur after her CHIP perinatal coverage ends.

Related Policy

Federal Poverty Level (FPL), C-131.1
Type Programs (TP) and Type Assistance (TA), C-1150
Adding a New Child, D-1433.1

D-120, Eligibility Qualifications

Body

D—121 Children's Health Insurance Program (CHIP)

Revision 15-4; Effective October 1, 2015

CHIP

A child must:

- be ineligible for Children's Medicaid;
- not be on Medicare;
- reside in Texas;
- be under age 19;
- be a U.S. citizen or non-citizen with valid proof of immigration/alien status;
- have total household net income at or below the applicable income limit; and
- be uninsured for at least 90 days or claim one of the good cause exemptions to the waiting period explained in D-1723.6, Good Cause Exemptions for Children Subject to the 90-day Waiting Period.

D—122 CHIP Perinatal

Revision 15-4; Effective October 1, 2015

CHIP Perinatal

To be eligible for CHIP perinatal, a woman must:

- be pregnant;
- reside in Texas;
- have total household net income at or below the applicable income limit, depending on family size; and
- be ineligible for ongoing Medicaid and CHIP because of income or immigration status.

A pregnant woman is considered to be an adult the month of her 18th birthday.

A pregnant woman must be determined ineligible for Medicaid and CHIP before being tested for perinatal eligibility. CHIP perinatal coverage begins the first day of the month in which the eligibility determination is made.

The woman's age is calculated as of the month in which the proposed effective date of coverage will occur.

D—122.1 Post-Birth Eligibility Determination

Revision 15-4; Effective October 1, 2015

CHIP Perinatal

A woman is not eligible for perinatal coverage if she applies after the child is born. The advisor must deny the application upon becoming aware that the pregnant woman has delivered or had a miscarriage before the eligibility determination is made. The advisor must then determine whether the newborn is eligible for Medicaid or CHIP.

If the pregnant woman delivers or has a miscarriage before the eligibility determination and the advisor becomes aware of the delivery or miscarriage after the eligibility determination has been made, the woman's coverage is terminated. The woman will receive one month of CHIP perinatal coverage.

D—122.2 Notification of Birth

Revision 13-4; Effective October 1, 2013

CHIP Perinatal

Staff are notified of the perinatal child's birth via the:

- case authority who reports the child's birth by telephone or in writing;
- the newborn file; or
- birth notification from the health plan.

D-200, Application Processing

D-210, Application Procedures

Body

D-210 Application Procedures

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Applications may be received in person, by telephone, fax, email, Internet or mail. Texas Health and Human Services Commission (HHSC) Benefits Offices are equipped with telephones, lobby computers and fax machines for applicants to submit applications.

Households can apply using any of the Medical Program application channels explained in A-113, Application Requests and Submissions.

If the applicant fails to provide a name, address or signature on a faxed or mailed application, consider it an invalid application.

No interview is required for the Children's Health Insurance Program (CHIP) or CHIP perinatal. Schedule an appointment only upon the household's request.

On the same day of the application receipt, advisors mail the applicant form VR30, Texas Voter Registration Application. If the individual contacts HHSC to decline the opportunity to register to vote after receipt of form VR30, the advisors mail Form H1350, Opportunity to Register to Vote, to the individual for a signature. Advisors send Form H1350 for imaging when the individual returns the form and retain the form for at least 22 months.

Related Policy

Application Processing, A-100
Registering to Vote, A-1521

D-211 Application Assistance

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

If an applicant needs help completing the application packet, a volunteer or staff member must help. The person helping the applicant complete an application must initial the part he/she completed, or sign the application showing that he/she helped complete it.

D-212 Applications Received by Fax, Email, Mail or Internet

Revision 20-4; Effective October 1, 2020

CHIP and CHIP Perinatal

The applicant's file date is the date the Texas Health and Human Services Commission (HHSC) or an HHSC agent receives an application that contains, at a minimum, the person's name, address and signature. A faxed or electronic signature (if using the online application available through YourTexasBenefits.com) is acceptable. A typed signature is not valid if the application is received via fax, mail or in person. If the application does not contain a signature, return the application with Form H1020, Request for Information or Action, requesting a signature.

The file date is the date an application is received at an HHSC Benefits Office or online through YourTexasBenefits.com during state business hours. For applications received outside of state business hours, the file date is established as the next business day.

Once the initial application disposition occurs, requests for coverage for additional types of assistance are handled separately and a new application is required.

D-213 Applications Received by Telephone

Revision 17-1; Effective January 1, 2017

CHIP, CHIP Perinatal

The file date is the date the applicant submits the application by telephone through 2-1-1, and the telephonic application contains the applicant's:

- name;

- address; and
- signature by telephone.

An applicant may complete and sign an application by telephone following the policy for Medical Programs explained at A-122.1, Application Signature.

Related Policy

Application Signature, A-122.1

D-214 Withdrawal of an Application

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

A person with case authority may submit a request to voluntarily disenroll a member. The case authority person must sign and submit the request in writing.

D-215 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

A household may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

D-220, Reopening an Application

Body

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

When a household is denied for failure to provide information, the household has until the 60th day after the file date to provide the information without submitting a new application. The date the household submits all of the missing information becomes the new file date. Review the information provided by the household with the information listed on the application to ensure all information remains accurate.

If the household submits the missing information after the time frame, the household must reapply by submitting a new application.

D-230, Application Processing Time Frames

Body

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Provide Form TF0001, Notice of Case Action, by the:

- 45th day after the file date for an application requesting health care for children.
- 15th working day after the file date for an application requesting health care coverage for a pregnant woman.

D—231 CHIP Perinatal Application

Revision 18-1; Effective January 1, 2018

CHIP Perinatal

Pregnant women who apply for medical assistance are screened for Pregnant Women Medicaid (TP 40). If ineligible for Medicaid, pregnant women under age 19 are tested for CHIP. If ineligible for CHIP because of age, income, or immigration status, pregnant women are tested for

CHIP perinatal.

Women certified on CHIP perinatal due to not meeting immigration status requirements and whose household income is at or below Medicaid for Pregnant Women income limits at the time of application must submit Form H3038, Emergency Medical Services Certification, or Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification, to cover the costs of labor and delivery.

Accept the applicant's (pregnant woman's, case name's or authorized representative's) verbal or written statement of pregnancy, including the start month, number of children expected and the anticipated date of delivery, unless questionable. The woman's statement would be considered questionable if the information provided regarding the due date is discrepant, such as the pregnancy start month and pregnancy end month are less than or more than nine months apart or if the woman reports a pregnancy with overlapping start and end months.

If questionable, verify the applicant's pregnancy by using:

- Form H3037, Report of Pregnancy; or
- other documentation containing the same information as Form H3037.

The verification must be from an acceptable source such as a physician, hospital, family planning agency, or social service agency.

A physician, nurse, advanced nurse practitioner or other medical professional must sign Form H3037 or another document for it to be considered verification from a medical source. If it is completed by another medical professional, ensure that the information about the supervising physician is provided.

The application contains a field for the number of children expected and the anticipated date of delivery, but does not contain a field for the applicant to enter the pregnancy start month. Staff must use the following procedures when certain information regarding pregnancy is left blank on any application for benefits:

- If the only item missing on the application form is the pregnancy start month, staff must count nine months back from the pregnancy end month to determine the pregnancy start month. The pregnancy end month is month zero.
- If the only item missing on the application form is the pregnancy end month, staff must count nine months from the pregnancy start date to determine the anticipated date of delivery. The pregnancy start month is month zero.
- If both the pregnancy start and end months are missing, attempt to obtain the information by phone. If unable to obtain the information by phone, send Form H1020, Request for Information or Action, to request the information.

If the pregnancy verification is not received by the 15th workday from the request, deny the application. See D-220, Reopening an Application, if the verification is provided after the application is denied.

Related Policy

Pregnancy, A-144.5

D—231.1 Minor Pregnant Women with Potential Medicaid Eligibility

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

If an application is received for a minor pregnant woman, request all missing information and test for potential Medicaid eligibility.

D-240, Missing Information Processing for Applications

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

If additional information is required, send the household Form H1020, Request for Information or Action. Upon receipt of the missing information, determine if the household is eligible.

Allow the household until the final due date to provide all the missing information. If the missing information is not provided by the final due date, deny the application.

If the missing information is received after the application is denied, but by the 60th day, reopen the application following the policy explained in D-220, Reopening an Application.

D-300, Household Composition

D-310, Certified Group

Body

Revision 17-2; Effective April 1, 2017

CHIP

A child may be eligible from birth through the month of the child's 19th birthday. Age is self-declared.

The certified group contains only the Children's Health Insurance Program (CHIP) eligible child. Only one child is certified per Eligibility Determination Group (EDG).

CHIP Perinatal

A pregnant woman of any age may qualify for perinatal coverage.

When the pregnant woman is age 18 and it is anticipated that she will turn age 19 before her CHIP enrollment start date, the CHIP coverage is denied. She is tested for Pregnant Women Medicaid (TP 40) and then for CHIP perinatal, if ineligible for Pregnant Women Medicaid (TP 40). If eligible for CHIP perinatal, her enrollment start date is the first day of the eligibility determination month.

Only one pregnant woman is certified per EDG.

If the mother's income is:

- **Above** the applicable income limit for Pregnant Women Medicaid (TP 40), as defined in C-131.1, Federal Poverty Income Limits (FPIL), the mother will be the only individual on the EDG for the majority of the certification period. During the month the child is born, the mother and the child are certified on the same EDG. After the month the child is born, the child is the only individual certified on the EDG.
- **At or below** the applicable income limit for Pregnant Women Medicaid (TP 40), as defined in C-131.1, and the mother receives Emergency Medicaid (TP 36) to cover the birth, the child will be certified on their own Medicaid for Newborn Children (TP 45) EDG.

CHIP, CHIP Perinatal

The following individuals are not eligible to receive CHIP or CHIP perinatal:

- Medicare recipients;
- inmates of a public institution; and
- residents of state supported living centers or institutions.

Exception: A child who is institutionalized (except for inmates of a public institution) during the child's continuous enrollment period remains eligible until the CHIP redetermination.

D-320, Budget Group

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Modified Adjusted Gross Income (MAGI) household composition is used to determine whose needs, income, and expenses are considered in determining an individual's eligibility for CHIP and CHIP perinatal. Each MAGI household composition is determined on the individual level. Individuals living at the same physical address may have a different MAGI household composition. MAGI household composition is based on federal income tax rules.

An individual does not have to file a federal income tax return to apply for CHIP or CHIP perinatal.

D—321 Who Is Included

Revision 16-4; Effective October 1, 2016

CHIP, CHIP Perinatal

Advisors must follow the policy described in A-240, Medical Programs, to determine who should be included in each individual's MAGI household composition.

CHIP

When determining eligibility for a pregnant child, the expected number of the pregnant child's unborn children are included in the pregnant child's MAGI household composition.

CHIP Perinatal

When determining eligibility for a pregnant woman, the expected number of unborn children are included in the pregnant woman's MAGI household composition.

If the CHIP perinatal MAGI household composition includes other pregnant women, the expected number of unborn children of the other pregnant women are also included in the CHIP perinatal MAGI household composition, regardless of whether the other pregnant women are certified on a medical program.

Related Policy

Inclusion of the Unborn, A-241.1.5

D—322 Who Is Not Included

Revision 16-4; Effective October 1, 2016

CHIP, CHIP Perinatal

Advisors must follow the policy described in A-240, Medical Programs, to determine who should be included in each individual's MAGI household composition.

CHIP

The expected number of unborn children are not included in a non-pregnant child's MAGI household composition for CHIP when a pregnant child is included in the household.

D—323 Minor Parent Situations

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Advisors must follow the policy described in A-240, Medical Programs, to determine who should be included in each individual's MAGI household composition.

D-330, Joint Custody

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Either parent may apply on behalf of the child(ren) if they meet the criteria explained in A-121, Receipt of Application for Medical Programs. A custodial parent is established based on the policy explained in A-240, Medical Programs, Living Arrangements.

D-340, Children in State Hospitals

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Children in state hospitals may be eligible as independent children for a 12-month period. In order to be admitted to a state hospital, the child must:

- be under age 19;
- be a U.S. citizen or Lawful Permanent Resident who entered the U.S. prior to Aug. 22, 1996;
- be a ward of HHSC via court civil commitment; or
- have or obtain a Social Security number (SSN).

A representative from the state hospital completes the application and attaches a cover sheet to specify the application is from the state hospital. In addition, the representative attaches copies of unpaid medical bills and, if applicable, Form H1113, Application for Prior Medicaid Coverage.

The application lists the:

- independent child's name as the head of household;
- SSN;
- date of birth;
- parents or UNKNOWN in other parent section;
- income and resources (if any);

Note: Resources are not considered as a factor in determining eligibility for CHIP or CHIP perinatal.

- insurance information;
- dates of service may be in the month of the child's 19th birthday or sooner;
- representative from the state hospital in the authorized representative section;
- signature of the representative from the state hospital who completed the application; and
- address of the state hospital in the residence and mailing address section, except for Terrell State Hospital (Terrell State Hospital lists the independent child's original residence address and the facility address in the mailing address).

If the independent child has no income, no other information is required to complete the application processing.

CHIP

An institutionalized child is not eligible to apply for CHIP. **Exception:** When a child is currently enrolled in CHIP and enters a state mental health facility, the child remains enrolled in CHIP until the end of the child's current enrollment segment.

D-400, Citizenship and Alien Status

D-410, General Policy

Body

Revision 15-4; Effective October 1, 2015

CHIP

An individual must be a U.S. citizen or alien with acceptable status to qualify for the Children’s Health Insurance Program (CHIP). The date of entry does not apply.

Review the alien status document from the U.S. Citizenship and Immigration Services (USCIS) and status code to determine the immigration/alien status. Refer to A-342, TANF and Medical Programs Alien Status Eligibility Charts.

CHIP Perinatal

A pregnant woman does not have to meet the citizenship or alien status requirements in order to be eligible for CHIP perinatal.

Applicants who possess temporary visas are eligible for CHIP perinatal as long as they meet residency eligibility requirements. See D-700, Residency.

Pregnant women potentially eligible for Medicaid who fail to provide verification of citizenship or alien status are not eligible for CHIP perinatal.

D-420, Citizenship

Body

Revision 11-4; Effective October 1, 2011

CHIP, CHIP Perinatal

U.S. citizens meet the citizenship criteria for CHIP and CHIP perinatal. U.S. citizens are persons born:

- in the 50 states, District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, America Samoa, Swain's Island or Northern Marianna Islands; or
- abroad to at least one parent who is a U.S. citizen. The child may claim derivative citizenship.

D-430, Immigration/Alien Status

Body

Revision 23-2; Effective April 1, 2023

CHIP

Qualifying immigrants and non-immigrants, as defined in A-311.1, Definition of Qualified Immigrant, are eligible for CHIP regardless of the date of entry. Review the alien status document and code to determine if the child meets the immigration or alien status requirements. Refer to A-342, TANF and Medical Programs Alien Status Eligibility Charts.

CHIP Perinatal

Immigration or alien status is not applicable to CHIP perinatal.

D-440, Verification

Body

D—441 Citizenship

Revision 11-4; Effective October 1, 2011

CHIP

CHIP applicants or recipients who declare that they are U.S. citizens must provide verification of citizenship.

Use Medicaid Programs proof/verification sources found in A-358.1, Citizenship, for citizenship and A-621, Verification Sources, for identity.

CHIP Perinatal

Citizenship is self-declared.

D—441.1 Reasonable Opportunity to Provide Citizenship and Alien Status Verification

Revision 15-4; Effective October 1, 2015

CHIP

CHIP applicants or recipients who declare themselves to be a U.S. citizen or declare an alien status, but for whom verification is unavailable, must be allowed a period of reasonable opportunity explained in A-351.1, Reasonable Opportunity.

D—441.2 Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship

Revision 15-4; Effective October 1, 2015

CHIP

If an applicant has a Social Security number, use SOLQ or WTPY to verify citizenship. See A-351.2, Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship.

D—442 Using Systematic Alien Verification for Entitlements (SAVE) Program to Verify Alien Status

Revision 15-4; Effective October 1, 2015

CHIP

Access the Verification Information System (VIS) through the USCIS using the Department of Homeland Security's SAVE program for verification validity.

Do not reverify an alien’s documents if the non-citizen status was previously verified and documented, and the documents have not expired. If the USCIS document is expired, and the alien wants to continue receiving or reapplies for benefits, then request updated documents. If the family fails to provide the updated documents, the child cannot receive benefits.

CHIP Perinatal

Immigration status is self-declared. The pregnant woman may be:

- a U.S. citizen,
- a lawful permanent resident, or
- an undocumented alien.

Do not trigger missing information for immigration status or date of entry.

CHIP, CHIP Perinatal

If the applicant provides documents other than those listed in A-358.2, Alien Status, take the following action to request additional verification:

- complete Form G-845, Document Verification Request;
- attach fully readable photocopies (front and back) of original immigration documents containing the alien's registration number; and
- mail one set of copies to the USCIS office serving the county of application (see the instructions to Form G-845).

If the applicant's name changed since the alien registration card was issued, the applicant must provide verification of the change.

If the alien is otherwise eligible, do not delay or deny the child's eligibility while waiting for a response from USCIS. When USCIS returns Form G-845, follow these procedures:

If the response indicates that the alien's document is...	then ...
valid,	document the detailed information and send the documents for imaging.
not valid and the child is enrolled,	• take adverse action to disqualify the child or deny the case, as appropriate; and • process a fraud referral.

D-500, Social Security Number

D-510, General Policy

Body

Revision 20-2; Effective April 1, 2020

CHIP

All applicants must provide a Social Security number (SSN) or apply for one through the Social Security Administration (SSA) before certification.

CHIP follows the SSN policy in A-400, Social Security Number, under the All Programs or Medical Programs headings.

CHIP Perinatal

A pregnant woman is not required to provide or apply for an SSN.

The applicant is not required to provide SSNs for other members included in the budget group. If SSNs are provided, staff record and may attempt to verify the SSN using the procedures explained in A-440, Verification Requirements. If verification is not available through electronic data sources, verification of the SSN must not be requested from the applicant.

D-520, Reserved for Future Use

Body

Revision 20-2; Effective April 1, 2020

D-600, Identity

D-610, General Policy

Body

D—611 Application

Revision 15-4; Effective October 1, 2015

CHIP

Advisors must verify the identity of all individuals applying for Medical coverage. Once identity has been verified for an individual, advisors do not re-verify.

CHIP Perinatal

Identity is self-declared.

D—612 Renewals

Revision 15-4; Effective October 1, 2015

CHIP

Advisors must verify the identity of the certified individual if identity has not been previously verified.

D-620, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

CHIP

Birth records and other official records are preferred sources of verification.

Advisors use proof/verification sources from the list under Medical Programs in A-621, Verification Sources. Once identity has been verified for an individual, advisors do not re-verify.

Note: If an applicant/recipient receives reasonable opportunity, verification of identity will be required when the reasonable opportunity period expires.

D-630, Documentation Requirements

Body

Revision 10-2; Effective April 1, 2010

CHIP

Document the source of identity proof/verification.

D-700, Residency

D-710, General Policy

Body

Revision 11-4; Effective October 1, 2011

CHIP, CHIP Perinatal

An eligible applicant must be a Texas resident. Residency in Texas is self-declared. An applying person does not lose resident status when out of state for less than a 12-month period.

Applicants meet the residency requirement if they live in Texas and intend to make Texas their home. The household is not required to have a permanent dwelling or fixed residence. A Texas residence address listed on the application meets the "intent to make Texas their home" rule.

People who live in Texas for a temporary purpose do not meet the residency requirement.

Migrant and itinerant workers meet the residency requirement when applying if they:

- live in Texas,
- entered Texas with a job commitment or an intention to seek employment (regardless of current employment status), and
- do not receive assistance from another state.

D-800, Child Support

D-810, General Policy

Body

Revision 11-4; Effective October 1, 2011

CHIP, CHIP Perinatal

Child support requirements do not apply to CHIP. Applicants may obtain child and medical support assistance by contacting the Office of Attorney General.

D-900, Resources

D-910, General Policy

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Resources are not considered as a factor in determining eligibility for the Children's Health Insurance Program (CHIP) or CHIP perinatal.

D-1000, Income

D-1010, General Policy

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Income is any type of payment that is of gain or benefit to a household. Income is either counted or exempted from the budgeting process. Earned income is related to employment and entitles a household to deductions not allowed for unearned income. Unearned income is income received without performing work-related activities. It includes benefits from other programs. To determine the date income can reasonably be anticipated, the advisor should use factors specific to the source of income, distance it has to travel through the mail, weekends and holidays.

Advisors must use Modified Adjusted Gross Income (MAGI) rules to determine financial eligibility for the Children's Health Insurance Program (CHIP) and CHIP perinatal following the Medical Programs policy, explained in A-1300, Income.

D-1020, Income Limits

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Income limits for CHIP and CHIP perinatal are defined in C-131.1, Federal Poverty Income Limits (FPIL).

D-1030, Types of Income

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Use the Medical Programs policy, explained in A-1320, Types of Income, to determine the countable and exempt income types for CHIP and CHIP perinatal.

D-1040, Reserved for Future Use

D-1050, Calculating Household Income

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

For CHIP and CHIP perinatal, each individual's MAGI household income is calculated following the Medical Programs policy explained in A-1341, Income Limits and Eligibility Tests.

D—1051 Income Frequency

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Income received must be converted to a monthly amount, unless received monthly. Advisors must use the following conversion factors. (Monthly pay means that the employee is paid once a month.)

Income Frequency	Conversion Factor
Weekly (paid once every week)	Multiply by 4.33
Bi-weekly (paid every other week)	Multiply by 2.17
Semi-monthly (paid twice a month)	Multiply by 2.0
Annually (paid once a year)	Divide by 12

If the income frequency cannot be determined based on the information listed on the application or from the verification, the advisor must generate Form H1020, Request for Information or Action, to request the income frequency.

D—1052 Terminated Income

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income. If the income terminated in the application month, the advisor must request missing information to verify the termination. Self-declaration is not acceptable verification.

D—1053 Budget Months

Revision 15-4; Effective October 1, 2015

CHIP

The system will determine CHIP eligibility for the following months:

At Application

- Application month
- Process month

At Redetermination

The month following the last month of CHIP coverage.

D-1060, Verification Requirements

Body

D—1060 Verification Requirements

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Income verification requirements for CHIP and CHIP perinatal align with the Medical Programs policy explained in A-1370, Verification Requirements.

D—1061 Verification Sources

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Determining whether client-reported income is reasonably compatible with electronic data sources is the preferred method of wage verification for CHIP and CHIP perinatal. Reasonable compatibility is explained in A-1370, Verification Requirements, Medical Programs.

Other income verification sources for CHIP and CHIP perinatal align with the Children's Medicaid (TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48) policy explained in A-1371, Verification Sources.

D-1070, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Exempt Income

Document:

- why it is exempt, and
- the name and address or telephone number of the income source.

Terminated Income

Document:

- the name and address or telephone number of the income source, and
- vacation pay received before or after termination, including the dates received.

Income

Document the:

- date of each income statement or stub used;
- date income is actually received;
- date income is anticipated using factors such as time it has to travel via mail, weekends and holidays;
- name and address or telephone number of the income source;
- gross amount of income;
- frequency of receipt (such as weekly, every two weeks, semi-monthly, monthly); and
- calculations used.

Income Computations

Document verification and computation of household income at the initial application, when a change is reported and at each subsequent application/redetermination. Record all sources, amounts, dates and computations.

Other Income

Document the method used to verify income other than earned income. This documentation includes the type of income, the check or document seen, the date on the check or document, the amount recorded on the check or document, the date the income was verified and any computations performed to determine the total income.

Self-Employment

Document:

- the method for averaging income;
- deductions for the cost of doing business;
- the number of hours engaged in the enterprise;
- other factors used to determine the amount of income;
- that the individual was informed to keep self-employment records and receipts for verification purposes for future recertifications; and
- when using Form H1049, Client's Statement of Self-Employment Income, as the only source of verification, the reason Form H1049 is the only source of income.

D-1100, Deductions

D-1110, General Policy

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Households may be allowed the Modified Adjusted Gross Income (MAGI) deductions explained in A-1410, General Policy, for Medical Programs.

D-1120, Reserved for Future Use

Body

Revision 20-2; Effective April 1, 2020

D-1130, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The deduction verification requirements for the Children's Health Insurance Program (CHIP) and CHIP perinatal align with the Medical Programs policy explained in A-1440, Verification Requirements.

D—1131 Verification Sources

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The deduction verification sources for CHIP and CHIP perinatal align with those for Medical Programs explained in A-1441, Verification Sources.

D-1140, Documentation Requirements

Body

Revision 11-4; Effective October 1, 2011

CHIP, CHIP Perinatal

Document:

- amount of expense,
- who pays the expense,
- how often the expense is paid,
- to whom the expense is paid,
- calculations used to determine monthly amounts, and
- justification for not allowing the deduction.

D-1200, Third-Party Resources

D-1210, Health Insurance

Body

Revision 25-3; Effective July 1, 2025

CHIP, CHIP Perinatal

Third-party resources (TPR) are sources of payment for medical expenses not the recipient or Medicaid. TPR includes payments from private and public health insurance and from other liable third parties that can be applied toward the recipient's medical expenses. **Note:** Separate dental or vision plans, auto, workers' compensation, county medical discount cards, student accident, travel insurance or sports-related insurance are not considered TPRs.

Consider Medicare a TPR. Do not certify a Medicare recipient for the Children's Health Insurance Program (CHIP) or CHIP perinatal.

CHIP

Households that have health insurance where the monthly premium amount for the child or children is:

- less than 5% of the household's net income in the application month are not eligible for CHIP coverage.
- 5% or more of the household's net income in the application month are eligible for CHIP coverage. However, the household must drop the insurance before CHIP coverage begins. Children cannot be covered by CHIP and health insurance at the same time. These children are not subject to the 90-day waiting period.

Households that have health insurance where the monthly premium amount for the family's coverage that includes the child or children is:

- less than 9.5% of the household's net income in the application month are not eligible for CHIP coverage.
- 9.5% or more of the household's net income in the application month are eligible for CHIP coverage. However, the household must drop the insurance before CHIP coverage begins. Children cannot be covered by CHIP and health insurance at the same time. These children are not subject to the 90-day waiting period.

When the family reports a TPR at application or redetermination, send Form H1020, Request for Information or Action, to request:

- the coverage end date;
- the monthly premium amount for the child or children or for family coverage that includes the child or children; and
- information to verify the insurance policy.

Deny the CHIP Eligibility Determination Group (EDG) if the household does not provide the verification by the due date, and the verification is required for all certified group members. If the verification is not required for all members, only the affected person will be disqualified.

Acceptable verification of the private health insurance end date includes:

- health insurance ID card indicating the end date;
- letter from the employer indicating the end date; or
- the person's statement by phone or in writing.

If a household reports that it has obtained health insurance during the continuous enrollment period, document the change. Process the change at the next redetermination.

The Texas Integrated Eligibility Redesign System (TIERS) pends the TPR logical unit of work at redetermination when HHSC receives TPR information by the TPR interface for a child currently eligible for or enrolled in CHIP.

When a household reports a new child in the household, and the child is potentially eligible for CHIP, address TPR requirements following application procedures. Deny the CHIP EDG if the child has an active TPR but does not meet any of the good cause exemptions.

CHIP Perinatal

Pregnant women with any type of private health insurance are not eligible for perinatal coverage, even if the current health insurance does not provide maternity coverage. Pregnant women cannot be covered by perinatal and private health insurance at the same time.

The 5% and 9.5% rules for monthly premium costs compared to the household's monthly net income do not apply to CHIP perinatal.

Related Policy

Adding a New Child, D-1433.1
Third Party Resources Changes, D-1437
Health Insurance, D-1632.2

Good Cause Exemptions for Children Subject to the 90-Day Waiting Period, D-1723.6
Exceptions to the Continuous Enrollment Period, D-1731

D-1300, Case Disposition

D-1310, General Policy

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Case disposition is the result of the eligibility determination once all required information is obtained and an individual's notice of eligibility status is generated.

The notice explains if the case/application is pended, certified, sustained or denied.
The household must submit all missing information by the 45th calendar day from the file date. If the family fails to submit the required information timely, the application is denied.

When an eligibility determination is made, the household is notified of the child's eligibility status in writing. In addition, households must be informed in the denial and disenrollment letter of:

- their rights and responsibilities;
- right to request a review of the case decision; and
- commercial insurance options through a referral to the Texas Department of Insurance toll-free telephone number at 1-800-252-3439 and the website at www.texashealthoptions.com.

The system automatically sends individuals determined ineligible for Medicaid and the Children's Health Insurance Program (CHIP) at application, redetermination or when processing a change to the Marketplace for an eligibility determination for federal health care coverage programs.

To qualify for the federal health care coverage programs, all individuals must first be determined ineligible for Medicaid and CHIP. Advisors must test whether an individual is eligible for all Medical Programs. The Texas Works Medical Programs Hierarchy, explained in A-132.1, Medical Programs Hierarchy, does this automatically for most clients.

Note: Advisors must follow a manual process when retesting eligibility for a minor parent aging out of CHIP, as explained in A-2342.1, Retesting Eligibility.

D-1320, Notice of Decision

Body

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Form TF0001, Notice of Case Action, advises the household of the:

- potential household eligibility and who is potentially eligible;
- need for the household to return a health plan selection and enrollment fee, if required;
- reason the application was denied, terminated or reinstated;
- effective date of the denial, termination or reinstatement; and
- right to request a review.

D-1330, Correspondence Processing

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

CHIP correspondence refers to written documents or a request for review from a household or applicant for enrollment into CHIP. Correspondence may be submitted online at YourTexasBenefits.com, by fax, or through the mail. Uploaded, faxed, or hard copy correspondence documents are linked with the appropriate case. Types of correspondence may include:

- provider claims;
- plan transfer form or letter;
- letter requesting address or name change;
- missing information requested by CHIP through application processing;
- requests for disenrollment;
- enrollment requests;
- request for review of an eligibility or enrollment decision; and
- cost share updates.

D-1400, Changes

D-1410, General Policy

Body

Revision 24-2; Effective April 1, 2024

CHIP and CHIP Perinatal

Changes are situations in a household that may affect eligibility. Action must be taken on reported changes to ensure program integrity.

Cost share adjustments are handled by the Enrollment Broker at application, and redetermination.

When a change is processed that is missing required information, send Form H1020, Request for Information or Action, within one business day from the report date. Allow 10 full days to provide the requested information or verification. Action must be taken on the change within one business day of receipt of the missing information.

D-1420, Reporting Requirements

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Households must report the following changes to:

- address;
- intent to reside in Texas;
- the individuals living in the home;
- income, including sources of income, regular hours worked, and pay rate;
- Modified Adjusted Gross Income (MAGI) expenses;
- pregnancy termination;
- a child being institutionalized or dying; and
- medical insurance coverage.

Exceptions: A child is disenrolled if the child reapplies and becomes eligible for Medicaid or at the end of the month of the child's 19th birthday.

Process all other changes, including agency-generated changes, at the time of report.

D—1421 How to Report

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Persons with case authority may report changes by one of the following means:

- online through YourTexasBenefits.com;
- in person at a Texas Health and Human Services Commission Benefits Office;

- telephone;
- mail;
- fax;
- Form H1019, Report of Change, and;
- signed Form H1028, Employment Verification.

A person with case authority is an individual who has the authority to apply on the child's behalf, as explained in A-121, Receipt of Application, for Medical Programs.

D—1422 Receipts for Reported Changes

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Households may request a receipt to acknowledge the change report. The receipt includes the type of change(s) and the date reported. If an individual requests a receipt, issue Form H1800, Receipt for Application/Medicaid Report/Verification/Report of Change.

D-1430, Processing Requirements

Body

D-1431 Address Change Processing

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

The case address is updated when the household reports an address change.

If the household reports a change of address, the individual is mailed form VR30, Texas Voter Registration Application, to register to vote based on the new address. If the individual declines the opportunity to register to vote after receipt of form VR30, mail Form H1350, Opportunity to Register to Vote, to the individual for their signature. Send Form H1350 for imaging when the individual returns Form and retain Form for at least 22 months.

Related Policy

Registering to Vote, A-1521

D-1432 Moves

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

For moves within Texas, the case is updated to reflect the newly reported address.

For moves outside of Texas, the case is updated to reflect the:

- temporary address, if the move is temporary.
- address and disenrolls the child as soon as possible, if the move is permanent.

D-1433 Household Composition Changes

Revision 15-4; Effective October 1, 2015

CHIP Perinatal

No action is taken on a request to add or remove a non-certified person from an existing perinatal Eligibility Determination Group (EDG).

D-1433.1 Adding a New Child

Revision 23-2; Effective April 1, 2023

CHIP, CHIP Perinatal

A separate application is required;

- to start benefits for a new child being added if there is not an existing Medicaid or Children's Health Insurance Program (CHIP) EDG on the case; and
- if a household requests benefits for a sibling of a child released from a juvenile facility whose TP 44 eligibility is reinstated to a denied or newly created case.

CHIP

When a household reports a new child in the household, determine if the new child and other children in the household that are certified for CHIP meet Medicaid eligibility criteria. Certify the children for Medicaid if they are eligible. A new application is not required.

When a household reports a new child in the household and the child is potentially eligible for CHIP, third-party resources (TPR) requirements must be addressed following application procedures. Deny the CHIP EDG if the child has an active TPR but does not meet any of the good cause exemptions.

Note: If the Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) reports by the **TJJD or JPD Released** Logical Unit of Work (LUW) that a child was released from a juvenile facility and is now living in the household, TIERS automatically tests the child's eligibility for Medicaid.

If the new child is ineligible for Medicaid but eligible for CHIP and has siblings or a parent currently enrolled in the program, they are considered to meet good cause. TIERS calculates the new child's effective date of coverage for the next possible month following cutoff. The new child will receive the remaining months of coverage with the siblings or parent. The coverage end date is the same date as the child's currently enrolled siblings or parent. The new child may not receive the full 12 months of coverage and is required to renew coverage along with the child's siblings or parent on the scheduled renewal date.

Once the new child is determined eligible for CHIP, TIERS notifies the Enrollment Broker via an interface. The Enrollment Broker generates and mails a welcome letter to the household.

CHIP Perinatal

Income Above the Limit for Medicaid for Pregnant Women (TP 40)

A child born to a CHIP perinatal mother whose household income is above 198 percent of the federal poverty level (FPL), which is the applicable income limit for Pregnant Women Medicaid (TP 40), will have an effective date beginning with the date of birth and continuing through the remainder of the 12-month CHIP perinatal enrollment segment. The mother's perinatal coverage ends the last day of the child's birth month or the pregnancy's termination month. The mother will receive two postpartum visits even if they are beyond the birth month.

Example: A pregnant mother is approved for CHIP perinatal effective June 1. The child is born on Oct. 4. The newborn's effective date of coverage is Oct. 4, and the end date is May 30. The mother's perinatal coverage ends Oct. 31.

A perinatal child whose coverage ends, and who has siblings currently enrolled in CHIP, meets good cause upon determination of CHIP eligibility. The child's enrollment start date is the first day of the month following the perinatal end date. The child's CHIP end date is the end date of the existing CHIP enrollment segment. The child may not receive the 12 months of CHIP coverage and must renew eligibility in accordance with the existing CHIP redetermination date.

Income at or Below the Limit for Medicaid for Pregnant Women (TP 40)

A child born to a CHIP perinatal mother whose household income is at or below 198 percent of the FPL, which is the applicable income limit for Pregnant Women Medicaid (TP 40), and who receives Emergency Medicaid to cover the labor with delivery charges, will be enrolled in TP 45 coverage effective the date of birth. The mother's perinatal coverage ends the last day of the child's birth month or the pregnancy's termination month. The mother will receive two postpartum visits even if they are beyond the birth month.

Related Policy

Receipt of Application, A-121
CHIP Perinatal Application Process, A-128.3
Neonatal Intensive Care Unit (NICU) Newborn Process, A-126.3.1
Federal Poverty Level (FPL), C-131.1

D-1433.2 Child Leaves the Home

Revision 24-2; Effective April 1, 2024

CHIP

A certified child leaving the home may or may not affect their continued eligibility for CHIP based on their tax status, tax relationships, and family relationships under MAGI household composition rules. This is explained in A-240, Medical Programs.

When a child dies, terminate the child's eligibility effective the last day of the month the child died.

Follow policy in B-510, Termination of Medical Coverage for People Confined in a Public Institution, if the child is confined in any public institution, including a juvenile facility.

Related Policy

Termination of Medical Coverage for People Confined in a Public Institution, B-510
Persons Confined in a Texas County Jail, B-542
Child Placed in a Juvenile Facility, B-543

D-1433.3 Child Institutionalized

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

When a certified child enters a state hospital or institution for a temporary absence, the child remains enrolled for the remainder of the 12-month period. See A-920, Temporary Absence From the Home, to determine if stay is considered a temporary absence.

D-1433.4 Head of Household

Revision 20-1; Effective January 1, 2020

CHIP, CHIP Perinatal

Under MAGI household composition rules, explained in A-240, Medical Programs, a head of household leaving the home may or may not affect eligibility depending on that person's tax status, tax relationships, and family relationships.

When the current head of household dies or leaves the home, change the head of household to another responsible adult household member without requiring the remaining household members to reapply for benefits. An adult household member is someone 19 years or older.

If there is no responsible adult member identified in the household, and a child in the household is receiving benefits, send Form H1020 to notify the household that a responsible adult who is caring for the child must apply for benefits if the child continues to need assistance. If an application is not submitted by the Form H1020 due date, deny benefits since the whereabouts of the child is unknown.

Related Policy

Who Is Included, D-321
New Head of Household, D-1632.1

D-1434 Demographic Changes

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

A demographic change is a change to a person's identifying information, such as date of birth, Social Security number (SSN), gender or name.

Process these changes and do not interrupt the child's continuous coverage.

D-1435 Pregnancy Reports

Revision 26-1; Effective Jan. 1, 2026

CHIP

When a household reports a CHIP child's pregnancy before her CHIP end date, test the pregnant child for Medicaid for Pregnant Women (TP 40) and request verification of the pregnancy. Accept a verbal or written statement of pregnancy from the pregnant child, head of household, or

authorized representative that includes the pregnancy start month, number of children expected, and the anticipated date of delivery. If eligible and the household provides the pregnancy verification, terminate CHIP and certify the pregnant child for Medicaid.

If the pregnant child is determined ineligible for Medicaid for Pregnant Women (TP 40), she remains continuously eligible for CHIP through the end of the 12-month postpartum period, unless she:

- voluntarily withdraws;
- no longer lives in Texas;
- is ineligible due to agency error or fraud, abuse or perjury attributed to the person; or
- dies.

If the household does not report a CHIP child's pregnancy until she gives birth or later, the child remains on CHIP, and the CHIP child's newborn is tested for Medicaid eligibility. If eligible, the newborn is certified for Children Under Age One Medicaid (TP 43). If not eligible, the newborn is enrolled in the mother's CHIP health plan. The effective date of the newborn's CHIP coverage is the next possible month following cutoff. The newborn's CHIP coverage ends with the household's current enrollment segment.

If a new pregnancy is reported for a CHIP child during her 12-month postpartum period, update the Pregnancy Logical Unit of Work (LUW) to test for and transition the pregnant child to Medicaid for Pregnant Women (TP 40), if eligible. If ineligible for Medicaid for Pregnant Women (TP 40) but eligible for CHIP, start a new CHIP certification period for the pregnant child based on the new pregnancy. If the pregnant child is only eligible for CHIP Perinatal based on the new pregnancy, keep the pregnant child's original CHIP certification period through the end of the 12-month postpartum period.

If a CHIP child voluntarily withdraws from CHIP or moves out of Texas during her pregnancy or postpartum period, terminate CHIP coverage. If the child later reapplies, process the application and certify the appropriate coverage.

Note: The child is not eligible for the rest of her initial 12-month postpartum coverage. Based on the new application, she may be eligible for a new CHIP certification period on a basis other than pregnancy.

Exceptions: If a CHIP child becomes eligible for one of the following types of assistance during her pregnancy or postpartum period, transition the child and terminate CHIP coverage:

- Supplemental Security Income (SSI);
- Medicaid for the Elderly and People with Disabilities (MEPD);
- Department of Family and Protective Services (DFPS);
- Children's Medicaid; or
- Medicaid for Breast and Cervical Cancer (MBCC).

Related Policy

Adding a New Child, D-1433.1

D-1436 Income and Deduction Changes

Revision 21-2; Effective April 1, 2021

CHIP

When a household reports a change in income, test the child or children for Medicaid eligibility. A new application is not required. If the child is still eligible for CHIP and the household requests that its cost share responsibilities be recalculated, refer the household to the Enrollment Broker.

D-1437 Third Party Resources Changes

Revision 15-4; Effective October 1, 2015

CHIP

If a household reports that they have obtained health insurance during the continuous enrollment period, document the change and process the change at the next redetermination.

Related Policy

Health Insurance, D-1632.2

CHIP Perinatal

Do not take any action if a woman reports private health insurance coverage during her certification period.

D-1600, Redeterminations

D-1610, General Policy

Body

Revision 15-4; Effective October 1, 2015

CHIP

Individuals enrolled in the Children's Health Insurance Program (CHIP) must complete the administrative renewal process explained in B-122.4, Medical Program Administrative Renewals.

Depending on the renewal status outcome and client action, final eligibility determinations for CHIP may be made manually by advisors processing renewal documents or automatically by the system.

For individuals required to return a renewal packet, advisors must process the manual renewal as explained in B-122.4.2, Processing a Manual Renewal, while following the timelines explained in D-1630, Timely Redeterminations, and D-1631, Redetermination Processing Time Frames.

CHIP Perinatal

There is no redetermination of CHIP perinatal coverage. The household is mailed a packet during the ninth month of eligibility, allowing the household to apply for medical coverage for the child.

D-1620, Notice of Redetermination or Certification Expiration

Body

Revision 21-4; Effective October 1, 2021

CHIP

Renewal correspondence for people enrolled in CHIP is generated following the same process used for Children’s Medicaid.

CHIP Perinatal

A packet is mailed to the household after cutoff in the ninth month of coverage. This mailing occurs over a five-day period. The household is instructed to complete the application, attach verification and return within seven days from the date on the letter.

In the 10th month of the perinatal enrollment segment, TIERS determines if the case has both a CHIP and a CHIP perinatal Eligibility Determination Group (EDG). If the CHIP perinatal enrollment segment ends before the end of the CHIP enrollment segment, the perinatal child is added to the CHIP EDG if the child is not eligible for Medicaid.

Related Policy

Notice of Redetermination/Certification Expiration, B-121

D—1621 Redetermination Reminder Notifications

Revision 15-4; Effective October 1, 2015

CHIP

Form H1014-A, Children’s Health Care Benefits – Final Reminder, is mailed to individuals who are required to return a signed renewal form as part of the administrative renewal process, as explained in B-122.4, Medical Program Administrative Renewals, and have not returned the packet. Form H1014-A is sent to individuals who have not responded by the first calendar day of the 11th month of coverage.

The letter reminds households that coverage will end if the completed redetermination form is not received.

D-1630, Timely Redeterminations

Body

Revision 15-4; Effective October 1, 2015

CHIP

A CHIP redetermination is considered received timely when received by cutoff of the 11th month of the certification period. This allows time for the enrollment process to be completed by the cutoff of the 12th month to avoid the client having a break in coverage.

D—1631 Redetermination Processing Time Frames

Revision 21-4; Effective October 1, 2021

CHIP

For households that are required to return a CHIP renewal form, process renewals received timely or untimely, by the 30th day from the date the renewal form is received, or by cutoff of the 11th month of the certification period, whichever is later.

When an acceptable Medical Program renewal form is not returned, the system automatically makes an eligibility determination through a mass update based on the eligibility outcome from the automated renewal process.

The automated renewal process does not require staff to run eligibility or dispose the EDG. Households receive a Form TF0001, Notice of Case Action, after cutoff in the 11th month. Children will continue to receive coverage until the end of their 12-month certification period.

Process renewal forms received after the date of denial following the policy for processing untimely redeterminations for TP 08, TP 43, TP 44, and TP 48.

Related Policy

Processing Untimely Redeterminations, B-124

D—1632 Changes Reported at Redetermination

Revision 13-4; Effective October 1, 2013

D—1632.1 New Head of Household

Revision 15-4; Effective October 1, 2015

CHIP

Accept a renewal form as valid when it is received reflecting a new head of household who is not someone with existing case authority.

Take the following action:

- accept the application and link it to the existing case,
- create a new case number for the household, and
- certify the new case to begin the month after the old case coverage ends.

D—1632.2 Health Insurance

Revision 15-4; Effective October 1, 2015

CHIP

When a household reports that it has acquired health insurance, determine if:

- The monthly premium amount for the child(ren) is less than 5 percent of the household's net income; or
- The monthly premium amount for the family's health insurance that includes the child(ren) is less than 9.5 percent of the household's net income.

If the health insurance coverage meets one of the scenarios above, deny the CHIP EDG.

If the health insurance coverage does not meet either of the scenarios above, the child(ren) is(are) still eligible for CHIP, but the household must drop the insurance in order to continue to receive CHIP. Send Form H1020, Request for Information or Action, to the household requesting proof of the insurance end date. If the household does not provide proof, the child(ren) is(are) no longer eligible for CHIP. Deny the CHIP EDG.

Acceptable verification of the private health insurance end date includes:

- health insurance identification card indicating the end date,
- letter from the employer indicating the end date, or
- individual's statement by phone or in writing.

Related Policy

Health Insurance, D-1210
Third Party Resources Changes, D-1437
Exceptions to Continuous Enrollment Period, D-1731

D—1633 Missing Information

Revision 15-4; Effective October 1, 2015

CHIP

During the automated renewal process, electronic data is used to automatically verify the following required verifications for CHIP:

- Income and expenses, and
- Immigration status.

Depending on the outcome of the automated renewal process, the system generates and sends renewal correspondence, including Form H1020, Request for Information or Action, if more information is needed, to individuals enrolled in CHIP following the process explained in B-121, Notice of Redetermination/Certification Expiration, for TP 08 and Children's Medicaid (TP 43, TP 44 and TP 48).

All missing information must be received before cutoff of the 11th month of the coverage period to receive continuous coverage. If the missing information is received before cutoff of the child's 11th month of coverage, update the EDG with the new information. If the information is received after cutoff of the 11th month of coverage, there may be a break in CHIP coverage.

When a renewal is denied due to failure to provide information or verification, advisors follow the policy for TP 08, TP 43, TP 44 and TP 48 explained in B-122.3.2, Denied for Failure to Provide Information/Verification.

Households that complete the redetermination process (eligibility and enrollment) by cutoff in the 11th month of the eligibility period and remain eligible will be enrolled for a new 12-month period. If the individual fails to pay the enrollment fee by cutoff of the first month of the new 12-month period, the EDG is placed in a Pending Enrollment Fee and/or Plan Selection and/or TPR Delay status for up to three months. If the household pays the enrollment fee within the three months, the EDG is reinstated and the child(ren) receive the remainder of the 12-month enrollment segment beginning with the month of reinstatement.

D—1634 Redetermination Application Complete

Revision 13-4; Effective October 1, 2013

CHIP

Once the household completes the redetermination and is eligible for CHIP, health care coverage begins the first of the next possible month after the household pays the applicable enrollment fee.

Households that complete the redetermination process receive a Form TF0001, Notice of Case Action, indicating the potential outcome for each child. If an enrollment fee is due, the Enrollment Broker sends the household a payment coupon and return envelope. The enrollment fee due date is set to 10 calendar days.

D—1634.1 Missing Enrollment Fee

Revision 15-4; Effective October 1, 2015

CHIP

If a household completes the redetermination process, but does not pay the applicable enrollment fee by the cutoff date of the 12th month, the child receives a one-month extension of CHIP coverage. The Enrollment Broker mails the family a letter to inform the family of the one-month extension and the requirement to pay the enrollment fee by cutoff in the first month of the new 12-month period, in order to continue coverage. The extended month of coverage is counted as month one in the new 12-month enrollment segment.

The Enrollment Fee Extension (EFX) letter is mailed the first week of the first month of the new 12-month enrollment segment. The letter advises households that the household must pay the enrollment fee to continue the child(ren)'s coverage.

If the household:

- pays the enrollment fee by cutoff of the first month of its new 12-month period, then the child remains enrolled for the remainder of the 12-month period.
- does not pay the enrollment fee by cutoff of the first month of the new 12-month period, then the child is disenrolled. The EDG is placed in Pending Enrollment Fee and/or Plan Selection and/or TPR Delay status starting the second month, for a period of up to three months.

If the household pays the enrollment fee after the:

- cutoff of the first month in the new 12-month period, but before the cutoff of what would have been the second month, then the child is suspended for one month and reinstated the following month for the remainder of the 12-month enrollment segment.
- second month's cutoff and before the third month's cutoff, then the child is suspended for two months and reinstated the following month for the remainder of the 12-month enrollment segment.
- third month's cutoff and before the fourth month's cutoff, then the child is suspended for three months and reinstated the following month for the remainder of the 12-month enrollment segment.
- cutoff of the fourth month, the application is denied and the household must reapply.

Note: If the payment is returned with non-sufficient funds (NSF), an NSF letter is mailed to the household as if the household had not paid the enrollment fee, and the EDG is placed on Pending Enrollment Fee and/or Plan Selection and/or TPR Delay status the following month.

D—1635 Redetermination Applications Eligible for Medicaid

Revision 14-3; Effective July 1, 2014

CHIP

When processing a redetermination application, test the application for Medicaid eligibility. If a child in the CHIP household is eligible for Medicaid and the action is processed:

- before cutoff, CHIP coverage ends the last day of the current month. Medicaid coverage begins the first day of the next month.
- after cutoff, CHIP coverage ends the last day of the following month. Medicaid coverage begins the first day of the month following the next month.

Any children in the household who are ineligible for Medicaid remain on CHIP through the end of the current CHIP certification period. They are then certified with a new CHIP certification period if they continue to be eligible for CHIP.

A child who is eligible for Medicaid based on income, and who has reported that she is pregnant, is denied at the end of the next possible month and certified for Medicaid. If the pregnancy due date is later than the end date of her CHIP coverage month and she is not eligible for Medicaid, she continues on CHIP through the end of the current certification period. Certify her with a new certification period if she continues to be eligible for CHIP.

If the household no longer qualifies for CHIP, deny the CHIP EDG at the end of the CHIP certification period. Send the household Form TF0001, Notice of Case Action, notifying the household that the child is no longer eligible for CHIP.

Related Policy

Advisor Action for Determining Eligibility for Children, A-126.3

D-1700, Enrollment

D-1710, General Information

Body

Revision 25-3; Effective July 1, 2025

CHIP, CHIP Perinatal

Once determined eligible for the Children's Health Insurance Program (CHIP) or CHIP perinatal, households must complete the enrollment process to receive benefits. The enrollment process includes choosing a health and dental plan and paying an enrollment fee, if applicable.

CHIP

CHIP eligibility is prospective. TIERS provides the potential eligibility begin date and the enrollment broker provides the actual eligibility begin date.

Cutoff rules determine the earliest a child can be eligible for CHIP. When the Eligibility Determination Group (EDG) is disposed on or before the cutoff date, the potential eligibility begin date is the first of the month following the disposition month. When the EDG is disposed after cutoff, the potential eligibility begin date is the first of the second month after the disposition month.

Example 1 – Disposed on or before cutoff:

Disposed May 1, 2015, then eligible June 1, 2015.

Example 2 – Disposed after cutoff:

Disposed May 23, 2015, then eligible July 1, 2015.

Related Policy

Medicaid Termination, A-825
Enrollment Fees at Application, D-1821
Involuntary Disenrollment, D-1761
Denial at Redetermination, A-2342
Eligibility Transition from Medicaid to CHIP, B-123.4
Actions on Changes, B-631
Periodic Income Checks, B-637

D-1720, Enrollment Process

Body

Revision 20-4; Effective October 1, 2020

CHIP and CHIP Perinatal

The Enrollment Broker receives a daily enrollment request that consists of member information for the eligible members. The Enrollment Broker sends an enrollment packet or confirmation notice to households with eligible members within three business days of receipt of the eligibility information. The household completes the enrollment process by choosing a health plan and dental plan and by paying a fee, if applicable.

Once the enrollment process is complete, the household is mailed an enrollment confirmation letter confirming the child's enrollment start date.

Related Policy

Dental Providers, D-1751

D—1720.1 Enrollment Fees

Revision 26-1; Effective Jan. 1, 2026

CHIP

If the enrollment fee is not paid by the due date, all recipients enrolled in CHIP are disenrolled. The household must reapply for benefits and must follow normal CHIP eligibility processing.

If the enrollment fee is paid by the due date, all recipients remain enrolled in CHIP and receive the remainder of the 12-month CHIP certification period.

Note: Recipients that transfer to CHIP and do not owe an enrollment fee follow current policies and procedures. They are enrolled in CHIP and defaulted into a plan following cutoff rules.

Related Policy

Enrollment and Non-Sufficient Funds, D-1723.4
Involuntary Disenrollment, D-1761

D—1721 Enrollment Packets

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The enrollment packet includes a variety of information including a Welcome Letter, cost share requirement information, and health and dental plan choice information.

CHIP

Enrollment packets are mailed to all households. The enrollment packet includes the:

- enrollment/transfer form;
- enrollment return envelope;
- comparison chart of the value-added services provided by the health plans;
- explanation of CHIP benefits;
- Welcome Letter that includes –
  - cost sharing information, if applicable, specific to the income level of the household receiving the enrollment packet; and
  - cost share limit amount for households required to pay cost sharing. This amount is a percentage of the household's net income and reflects the maximum amount of health care expenses and cost sharing payments that a household is obligated to pay during a term of coverage.
- flier summarizing the importance of the health plan selection;
- CHIP member guide; and
- enrollment fee invoice and envelope, if applicable.

Households that are not required to pay an enrollment fee, or that paid the enrollment fee but did not select a health plan, are defaulted into the available health plan and sent an enrollment confirmation notice.

CHIP Perinatal

CHIP perinatal members are not subject to cost sharing. All members receive an enrollment packet. The enrollment packet includes the:

- enrollment/transfer form;
- enrollment return envelope;
- comparison chart of the value-added services provided by the health plans;
- explanation of benefits;
- flier summarizing the importance of the health plan selection; and
- CHIP perinatal member guide.

D—1722 Children with Special Health Care Needs

Revision 15-4; Effective October 1, 2015

CHIP

The enrollment packet includes a list of questions as determined by the Texas Health and Human Services Commission (HHSC) to identify Children with Special Health Care Needs (CSHCN).

Health plans evaluate and confirm whether a child meets the CSHCN criteria by contacting the self-identified families. If the plan determines the child does not meet the CSHCN criteria, the plan sends the CSHCN status determination to the Enrollment Broker.

The Enrollment Broker reports the number of CSHCN monthly.

D—1723 Selecting a Health Plan

Revision 19-1; Effective January 1, 2019

CHIP, CHIP Perinatal

Households can make a health plan selection by phone, online, or by submitting a completed Enrollment Transfer Form (ETF) by mail or fax. If making the selection by phone, the requirement for a signed enrollment form is waived.

Households that do not choose a health plan are automatically defaulted into a health plan. Families are notified that they have been defaulted and are given 90 days to choose a new health plan.

CHIP

People with case authority select the health plan for CHIP-eligible children. Households that fail to choose a health plan are defaulted into a health plan.

Information concerning CHIP health plans and the areas covered is available at Medicaid Medical and Dental Policies.

Upon completion of the enrollment process, the system triggers an Enrollment Confirmation Notice (ECN) that informs the household of each CHIP-eligible child's:

- unique identification number;
- enrollment start date;
- selected or assigned health plan;
- applicable copays; and
- cost share limit, if applicable.

The ECN includes a Medical Payments Form (MPF). The MPF helps the household track expenditures by date, event and amount. See D-1800, Cost Sharing.

If a child is subsequently added to a CHIP-enrolled case, the Enrollment Broker mails the household an ECN.

CHIP Perinatal

People with case authority select a health plan for CHIP perinatal eligible children. Households that do not select a health plan are defaulted into a health plan.

Information concerning CHIP perinatal health plans and the areas covered is available at
CHIP Perinatal FAQs.

Upon completion of the enrollment process, the system triggers an ECN that includes the pregnant woman's:

- unique identification number;
- enrollment start date; and
- selected or assigned health plan.

Related Policy

Health Plan Change, D-1740

D—1723.1 Enrollment Reminder Notification

Revision 13-4; Effective October 1, 2013

CHIP

Fifteen calendar days after the enrollment packets are mailed, an enrollment reminder notification is mailed to households that fail to select a health plan and/or pay the enrollment fee.

If the household does not respond within 90 calendar days of mailing the enrollment packet and the household fails to pay any required enrollment fee, the EDG is denied and the household must submit a new application.

D—1723.2 Missing Information Processing for Enrollment Forms

Revision 15-4; Effective October 1, 2015

CHIP

Missing information for an enrollment form must be received within 90 calendar days of the date the Welcome Packet is mailed.

When all missing information is received before cutoff of the month before the member's enrollment start date (and within 90 calendar days of the date the Welcome Packet is mailed), the Enrollment Broker updates the enrollment information and the child's/children's enrollment start date is recalculated to the first day of the next possible month.

After 90 calendar days from the day the Welcome Packet is mailed, if the enrollment fee is not received, the Enrollment Broker sends an eligibility request to deny for non-payment. The denial letter informs the household that the enrollment missing information was not received or was received beyond the required period, and the household must submit a new application and reapply.

D—1723.3 Address Change While Pending Enrollment

Revision 15-4; Effective October 1, 2015

CHIP

At initial application, health plan changes are allowed when the household moves to a new coverage service area and enrollment is complete, but pending a future enrollment start date due to the 90-day waiting period or cutoff.

D—1723.4 Enrollment and Non-Sufficient Funds

Revision 17-2; Effective April 1, 2017

CHIP

Households with children in a pended status, determined to have paid the enrollment fee with non-sufficient funds (NSF), do not receive health care coverage until the enrollment fee is received and processed. The household must submit the enrollment fee in full so that the child(ren) can be moved to a CHIP-eligible status. Households have 90 calendar days to submit the enrollment fee. If the household's payment is received before the due date, the child(ren) is (are) enrolled, based on the scheduled coverage date or the first month thereafter, and receives a new enrollment segment of 12 months.

If a child has an active enrollment segment and the Enrollment Broker determines the enrollment fee as NSF, the child is disenrolled at the next possible month, and the household must submit payment via money order, cashier's check, or debit or credit card via YourTexasBenefits.com. Once the household submits an acceptable payment, the Enrollment Broker re-establishes the child's enrollment the next possible month and provides the remaining months of coverage.

The following chart shows NSF situations and the action taken by the Enrollment Broker in each situation.

If the enrollment fee is...	then the Enrollment Broker...
returned with NSF before cutoff of the first month of a new 12-month enrollment period,	disenrolls the child and places the case in suspension starting in the second month for a period of up to three months.
submitted by a replacement payment after the extension month cutoff but before renewal month four cutoff,	reopens the case in the following month for the remainder of the 12-month period.
returned with NSF before the extension month cutoff and no replacement payment is made by renewal month four cutoff (the end of the suspension period),	does not reopen the case. The household must submit a new application.
returned with NSF after the extension month cutoff and a replacement payment is made before renewal month two cutoff,	continues enrollment for the remainder of the 12-month period.
returned with NSF after the extension month cutoff and a replacement payment is received after renewal month two cutoff but before renewal month three cutoff,	disenrolls the child and suspends the case for one month. The case is reinstated for the remainder of the 12-month period (nine more months).
returned with NSF after the extension month cutoff and a replacement payment is received after renewal month three cutoff but before renewal month four cutoff,	disenrolls the child and suspends the case for two months. The case is reinstated for the remainder of the 12-month period (eight more months).

If the enrollment fee is...	then the Enrollment Broker...
returned with NSF after the extension month cutoff and a replacement payment is not made before renewal month four cutoff,	does not reopen the case. The household must submit a new application.

Related Policy

Missing Enrollment Fee, D-1634.1

Expedited CHIP Enrollment

Households whose enrollment fee returns with NSF will be disenrolled and must reapply for benefits.

Related Policy

Expedited CHIP Enrollment, D-1711
Expedited CHIP Enrollment Process, D-1720.1

D—1723.5 Coverage Start Dates

Revision 15-4; Effective October 1, 2015

CHIP

If the enrollment process is completed prior to cutoff, the coverage start date begins the first of the following month, unless the household is subject to the 90-day waiting period or has a future Medicaid end date.

If the enrollment process is completed after cutoff, the coverage start date begins the first of the second month following the disposition month, unless the household is subject to the 90-day waiting period or has a future Medicaid end date.

Example 1 – Enrollment completed on or before cutoff:

Enrollment completed May 1, 2015; coverage starts June 1, 2015

Example 2 – Enrollment completed after cutoff:

Enrollment completed May 23, 2015; coverage starts July 1, 2015

For children subject to the 90-day waiting period, the coverage start date is 90 days (three calendar months) after the last month in which the child was covered by a third-party health benefits plan, as long as the enrollment fee is paid.

The waiting period only applies to children who were covered by a third-party health benefits plan (private health insurance) at any time during the 90 days (three calendar months) before the date of application for CHIP. The good cause exemptions apply to children subject to the waiting period. See D-1723.6, Good Cause Exemptions for Children Subject to the 90-day Waiting Period.

CHIP Perinatal

The coverage start date begins the first day of the month in which eligibility is determined. When the child is born, the child begins coverage on the date of birth. The mother may receive two postpartum visits.

D—1723.5.1 Coverage Start Date for Adding a Child

Revision 15-4; Effective October 1, 2015

CHIP

The CHIP coverage start date is coordinated with the Medicaid end date, if applicable.

D—1723.6 Good Cause Exemptions for Children Subject to the 90-day Waiting Period

Revision 15-4; Effective October 1, 2015

CHIP

The waiting period for CHIP enrollment may be waived if the household claims one of the following good cause exemptions:

- A parent's insurance benefit under the Consolidated Omnibus Budget Reconciliation Act of 1984 (COBRA) is terminated;
- A change in a parent's marital status;
- The child is no longer covered by the Texas Employee Retirement System;
- Loss of CHIP eligibility from another state;
- Involuntary loss of insurance coverage;
- The employer stops offering health insurance coverage for dependents (or any coverage);
- A change in employment, including involuntary separation, resulting in the child's loss of coverage (other than through full payment of the premium by the parent under COBRA);
- Loss of Medicaid coverage for any reason;
- Loss of coverage in any insurance affordability program, including Advanced Premium Tax Credits (APTCs), Cost Sharing Reductions (CSRs), Medicaid, and CHIP;
- The premium paid by the family for coverage of the child under the group health plan is more than 5 percent of the Modified Adjusted Gross Income (MAGI) household income;
- The premium that a family pays for the family's coverage that includes the child is more than 9.5 percent of the MAGI household income;
- Death of a parent;
- The child has special health care needs;
- HHSC determines that good cause exists based on information provided by the applicant or information otherwise obtained by the agency; or
- HHSC Directive — other reasons for an exemption that have not yet been defined by HHSC.

An applicant may declare good cause at any point during the application processing or after eligibility is determined. An applicant may claim a good cause exemption as follows:

- On Form H1010, Texas Works Application for Assistance — Your Texas Benefits:
  - Addendum, Section 5 – Insurance Offered Through Your Job; and
  - Appendix A, Health Coverage From Jobs;
- On Form H1010-M, Applying for or Renewing Medicaid or CHIP?:
  - Addendum, Section 5 – Insurance Offered Through Your Job; and
  - Appendix A, Health Coverage From Jobs;
- On Form H1205, Texas Streamlined Application:
  - Step 5 – Your Family's Health Coverage; and
  - Appendix A, Health Coverage From Jobs;
- Online at YourTexasBenefits.com;
- By telephone; or
- In writing.

Staff must accept the client's self-declaration of a good cause exemption to the CHIP 90-day waiting period, except as follows.

Staff must not grant the applicant or client a good cause exemption to the CHIP 90-day waiting period if:

- the applicant selects "other" as the reason the insurance from a job ended;
- the end date of the health insurance coverage from a job is left blank; or
- the cost of the insurance coverage from a job is left blank.

Children exempt from the 90-day waiting period whose households subsequently report a change that nullifies the exemption become subject to the 90-day waiting period. The child(ren)'s scheduled coverage date is determined from the date the eligibility determination is made.

CHIP Perinatal

There is no 90-day waiting period for CHIP perinatal. Good cause exemptions do not apply.

Note: A perinatal child whose coverage ends, and who has siblings currently enrolled in CHIP, meets good cause upon determination of CHIP eligibility. The system calculates the child's enrollment start date as the first day of the month following the perinatal end date. The child's CHIP end date is the end date of the existing CHIP enrollment segment.

D—1723.6.1 CHIP Good Cause and Account Transfers

Revision 15-4; Effective October 1, 2015

CHIP

If a client is determined eligible for CHIP but is subject to the 90-day waiting period, HHSC will transfer that individual's account information to the Marketplace to be assessed for eligibility for other health care coverage programs. This allows the individual access to coverage during the 90-day waiting period and to avoid sanctions for failing to acquire health coverage.

D-1730, Continuous Enrollment Period

Body

Revision 24-2; Effective April 1, 2024

CHIP

Children are granted 12 months of continuous coverage.

CHIP Perinatal

CHIP perinatal recipients are granted 12 months of continuous enrollment from the first day of the eligibility determination month. The 12-month period includes the months of CHIP perinatal coverage before and following birth. When the child is born, if the household's income was above the income limit for TP 40, defined in C-131.1, Federal Poverty Income Limits (FPIL), the child's coverage begins on the date of birth. The pregnant woman's coverage ends on the last day of the month that the child is born. The child's enrollment ends at the end of the original 12-month segment.

The child receives full CHIP benefits from the date of birth through the end of the continuous perinatal enrollment segment. Following delivery, the mother of the perinatal child qualifies for two postpartum care visits.

If a household reports a change in household size or income that would impact the household's eligibility, there is no disruption to the child's active enrollment segment.

D-1731 Exceptions to the Continuous Enrollment Period

Revision 26-3; Effective July. 1, 2026

CHIP

The following are exceptions to the period of continuous enrollment:

- a child added to the household who becomes eligible after a sibling’s coverage has begun, and eligibility is established to align certification periods;
- a 19-year-old child;
- a pregnant child eligible for Medicaid;
- child currently covered on Children's Medicaid;
- confirmation that the child remains on health insurance and the household did not drop the third-party resource (TPR) at application or redetermination;
- the household reports a change that makes the child eligible for Medicaid;
- confirmation that the child no longer lives in the state;
- the child or authorized representative (AR) requests voluntary disenrollment in writing;
- confirmation that eligibility was granted in error at the most recent determination or renewal of eligibility due to agency error or fraud, abuse, or perjury attributed to the child or AR;
- the child dies; or
- failure to pay required enrollment fees at application or redetermination for a child.

Note: A pregnant child who is ineligible for Medicaid but eligible and certified for CHIP receives continuous CHIP coverage even when the child turns 19.

CHIP Perinatal

The following are exceptions to the period of continuous enrollment:

- * current Medicaid coverage;
- confirmation of current health insurance coverage;
- confirmation that the woman or newborn no longer lives in the state;
- the AR requests disenrollment in writing;
- termination of pregnancy with no live birth;
- the birth is not reported by two months after the expected due date; or
- the mother was determined eligible after the birth month of the child.

* **Note:** The exception for current Medicaid coverage does not apply if the person receives one of the following Emergency Medicaid types of assistance: TP 36, TA 31, TP 32 or TP 34.

Related Policy

CHIP General Policy, D-110
Health Insurance, D-1210
Third Party Resources Changes, D-1437
Health Insurance, D-1632.2
Involuntary Disenrollment, D-1761

D-1732 Pregnant Members Aging Out of CHIP

Revision 25-1; Effective Jan. 1, 2025

CHIP

A pregnant CHIP member receives continuous CHIP coverage until the end of the 12-month postpartum period, even when the member turns 19 years old.

D-1740, Health Plan Change

Body

Revision 15-4; Effective October 1, 2015

CHIP

Households are eligible to change health plans for any reason up to 90 calendar days after the enrollment start date. There is no limit to the number of times a household may change plans within that time frame. In addition, households may change health plans once per year at redetermination for any reason or during the child's enrollment segment for specific reasons.

The household may request and complete a health plan transfer:

- by phone,
- in writing using the Enrollment/Transfer form submitted by fax or mailed to:

HHSC
PO Box 149023
Austin, TX 78714-9023

- by Interactive Voice Response (IVR), or
- online using YourTexasBenefits.com.

CHIP Perinatal

Households are eligible to change health plans for any reason up to 120 calendar days after the enrollment start date. There is no limit to the number of times a household may change plans within that time frame. Households may change health plans during the enrollment segment for specific reasons.

The household may request and complete a health plan transfer:

- by phone,
- in writing using the Enrollment/Transfer form submitted by fax or mailed to:

HHSC
PO Box 149023
Austin, TX 78714-9023

- by IVR, or
- online using YourTexasBenefits.com.

Related Policy

Plan Change During Current Enrollment Segment, D-1741

D—1741 Plan Change During Current Enrollment Segment

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Following the first 90 days of CHIP enrollment or 120 days for CHIP perinatal, a household is allowed to change health plans during the child's enrollment segment if the household:

- permanently relocates to a different health maintenance organization service delivery area.
- permanently relocates to a different location within a service area and this relocation would necessitate a change in primary care provider.
- has good cause to request a plan change. A household's request to change health plans on the basis of good cause can be approved in limited situations, and HHSC determines the situations that constitute good cause.
- is unable to receive the service the member is seeking because the plan does not cover the service because of moral or religious objections.
- needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- has other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

A household may submit a request for a health plan change or disenrollment to the Enrollment Broker, who reviews and considers each request on an individual basis. If the household disagrees with the decision, the household may request a review. The household, health plan and Enrollment Broker receive notification from HHSC regarding disposition of the review.

D—1742 Plan Change at Redetermination

Revision 15-4; Effective October 1, 2015

Households can change health plans once per year during redetermination.

If the household’s request for a health plan change is received by the cutoff date of the last month of the child's certification period, the ECN letter is sent to inform the household of the new health plan selection.

For a household with health plan change information processed after the cutoff date of its last month of certification, a grace period extends to the cutoff date of the first month of the child's new certification period. The household's CHIP coverage continues under the original health plan through the end of the first month of the child's new certification period. Coverage under the new health plan begins the first day of the following month. The household is sent the Health Plan Transfer (HCC) letter informing the household of the new health plan selection.

Health plan change requests received by the Enrollment Broker as part of the redetermination process are applied to the new certification period and do not affect the current certification period, unless the requests are submitted due to a change of address or other good cause reason.

Once the health plan change form is received and processed, additional enrollment health plan changes are granted for address changes and other good cause reasons only.

D—1743 Redetermination Indicates a Change of Address

Revision 15-4; Effective October 1, 2015

CHIP

If the redetermination form indicates a household moved and now has different health plan options, a Health Plan Change (HPC) letter is mailed to the household and includes:

- a health plan change form;
- a comparison chart that includes a value-added service matrix;
- the health plan change/redetermination instruction letter; and
- a self-addressed stamped envelope.

The health plan change/redetermination instruction letter informs the household they may change health plans:

- by phone,
- in writing using the Enrollment/Transfer form submitted by fax or mailed to:

HHSC
PO Box 149023
Austin, TX 78714-9023

- by IVR, or
- online using YourTexasBenefits.com.

The Enrollment Broker must receive the completed health plan change form before enrolling a household in a new health plan. A household that moves to an area of choice remains with its current health plan until the Enrollment Broker receives the completed health plan change form or the health plan transfer is completed by phone. If the household reports the change of address online, the household is also able to make a health plan change online. If the household does not return its completed health plan change form by the cutoff of its last month of certification, the household is enrolled in the next available health plan using a default process. The household is sent the ECN informing the household of the new health plan selection.

The child is enrolled in the designated health plan during the next certification period.

D-1750, Dental Benefits

Body

Revision 18-4; Effective October 1, 2018

CHIP, CHIP Perinatal

All children enrolled in CHIP are eligible to receive dental benefits. Dental benefits include both therapeutic and preventive services. CHIP perinatal pregnant women do not receive dental benefits. However, upon birth, the newborn is eligible for dental benefits. The dental benefit is for a 12-month period that is the same as the child's 12-month enrollment period. **Note:** Children with private dental insurance still qualify for CHIP.

Households are required to pay copayments for dental services. Assess dental office visit copays at the office visit copay rate. The applicable copayment requirements are:

Coverage Description	At or below 151% FPIL	Above 151% up to and including 186% FPIL	Above 186% up to and including 201% FPIL
Office visit	$5	$20	$25
Non-emergency ER visit	$5	$75	$75
Generic prescription	$0	$10	$10
Name-brand prescription	$5	$35	$35
Inpatient hospital care (per admission)	$35	$75	$125

D—1751 Dental Providers

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

DentaQuest and Managed Care of North America (MCNA) Dental are the dental managed care organizations (DMOs) for dental benefits. Eligible CHIP households receive an enrollment packet that provides information on the DMOs available in their area and how to choose a dental plan. The packet contains plan comparison charts, an enrollment form and a business reply envelope. A 30-day reminder letter is sent to households that have not made a dental plan selection. CHIP households make a dental plan selection through the following options:

- by phone,
- in writing using the Enrollment/Transfer form submitted by fax or mailed to:

HHSC
PO Box 149023
Austin, TX 78714-9023

- by IVR, or
- online using YourTexasBenefits.com.

Related Policy

Enrollment Process, D-1720

D-1760, Disenrollment

Body

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The applicant or someone with case authority may request disenrollment at any time. Disenrollment requests received and processed before the current month's cutoff are effective at the end of the current month unless the applicant requests a specific date. Disenrollment requests received after cutoff of the current month are effective the next possible month. When the request is due to death, the member is disenrolled effective the last day of the month the member died.

Upon completion of processing the disenrollment request, Form TF0001, Notice of Case Action, is sent to the household. Form TF0001 informs the household of the reason the member's coverage is ending.

Once eligibility has been terminated, members will be disenrolled.

Regardless of the disenrollment reason or month, if a member has received at least one month of CHIP coverage, the household is not eligible for a refund of the enrollment fee.

D-1761 Involuntary Disenrollment

Revision 26-3; Effective July 1, 2026

CHIP

Verbal notification is enough to generate an involuntary disenrollment for a CHIP-enrolled child. Reasons for involuntary disenrollment include:

- aging out when the child turns 19;
- the household moves out of state;
- the death of a child;
- a child is certified for Medicaid;
- notification of pregnancy;
- if a household is eligible for expedited CHIP enrollment while owing an enrollment fee and does not pay the fee by the due date;
- self-disclosure of the child's non-lawful permanent resident, non-qualified alien or non-U.S. citizen status; and
- direction by HHSC based on evidence that the child's original eligibility determination was wrong.

CHIP Perinatal

Verbal notification is enough to generate an involuntary disenrollment for women enrolled in CHIP perinatal. Reasons for involuntary disenrollment include:

- the pregnant woman is enrolled in Medicaid, which does not apply if the person receives one of the following Emergency Medicaid types of assistance: TP 36, TA 31, TP 32 or TP 34;
- a household submits a new application and specifically requests Medicaid in writing once the perinatal child is born;
- the confirmation is received that the pregnant woman has private health insurance;
- the woman is disenrolled on the last day of the month that the pregnancy terminates without a live birth, and the EDG is denied;
- no birth is reported by two months after the expected due date;
- a child with special needs, who requires neonatal intensive care, is retroactively disenrolled back to the child's date of birth; and
- a household moves out of state.

Related Policy

- CHIP General Policy, D-110
- Exceptions to the Continuous Enrollment Period, D-1731

D-1762 Health Plan Request to Disenroll a Member

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Based on Texas Department of Insurance guidelines, a limited number of situations exist when a health plan may request the disenrollment of a member from its plan.

The situations in which a health plan may request the disenrollment of a member are limited to one or more of the following:

- fraud or intentional material misrepresentation (coverage may be cancelled after not less than 15 days written notice from the Enrollment Broker to the member).
- fraud in the use of services or facilities (coverage may be cancelled after not less than 15 days written notice from the Enrollment Broker to the member).
- misconduct detrimental to safe plan operations and the delivery of services (coverage may be cancelled by the Enrollment Broker immediately).
- failure of the enrollee and a plan physician to establish a satisfactory patient/physician relationship if it is shown that the plan has, in good faith, provided the enrollee with the opportunity to select an alternative plan physician. The enrollee is notified in writing that the plan considers the patient/physician relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid disenrollment, and the enrollee has failed to make such changes (coverage may be cancelled 30 days following written notice from the Enrollment Broker to the member).

The Enrollment Broker has the option of enrolling the member in another health plan and notifies the second plan of the reason for disenrollment from the first.

D-1800, Cost Sharing

D-1810, General Information

Body

Revision 18-4; Effective October 1, 2018

CHIP

There are two types of cost share obligations – enrollment fees and copayments. Most CHIP eligible households are subject to cost share obligations. **Exceptions:**

- households with gross income at or below 151% of the Federal Poverty Income Limit (FPIL) are not subject to an enrollment fee;
- American Indians and Alaska Natives are exempt from all cost sharing. American Indian or Alaska Native status is self-declared on the application. If one child within the household is an American Indian or Alaska Native, the entire household application has American Indian or Alaska Native status; and
- unaccompanied refugee minors are exempt from all cost sharing.

Cost sharing is processed by the Enrollment Broker.

CHIP Perinatal

CHIP perinatal recipients are not subject to cost share obligations. Perinatal recipients do not pay enrollment fees or copayments.

D-1820, Enrollment Fees

Body

Revision 18-4; Effective October 1, 2018

CHIP

The enrollment broker assesses an enrollment fee before initial enrollment and at redetermination. The enrollment fee is money submitted by a family for CHIP coverage to the enrollment broker. The enrollment broker bases the amount of the enrollment fee on the household's FPIL. It

covers the continuous enrollment period. The enrollment broker assesses all enrollment fee requirements on a per-household basis, not on a per-child basis.

Enrollment fees are:

- $0 for households with net income at or below 151% FPIL;
- $35 for households with net income above 151% up to and including 186% FPIL; and
- $50 for households with net income above 186% up to and including 201% FPIL.

Related Policy

General Information, D-1810

D—1821 Enrollment Fees at Application

Revision 17-2; Effective April 1, 2017

CHIP

Eligible children cannot enroll and receive covered benefits before receipt of the enrollment fee.

Exception: Children determined eligible for expedited CHIP enrollment can enroll and receive covered benefits before receipt of the enrollment fee. See D-1711, Expedited CHIP Enrollment.

D—1821.1 Change During the Enrollment Process

Revision 13-4; Effective October 1, 2013

CHIP

If during the enrollment process, a reported change alters the cost share obligation, the child or children begin health care coverage based on the payment requirement of the current eligibility determination. The household is charged or credited the difference and a letter is sent to the household explaining the change.

D—1822 Enrollment Fees at Redetermination

Revision 13-4; Effective October 1, 2013

CHIP

Households must pay the enrollment fee at redetermination before continuing coverage.

D—1822.1 Request for Review and Continued Benefits

Revision 19-4; Effective October 1, 2019

CHIP

If the household is denied at redetermination due to income and requests a review and continued enrollment coverage before the stated deadline, the child continues to receive CHIP and the enrollment fee is waived until the request for review staff complete the eligibility review. If the request for review staff determine the household is eligible for CHIP, the Enrollment Broker will send the household an enrollment packet to request the applicable enrollment fees.

Related Policy

Enrollment Fees, D-1820
Request for Review. D-1920

D—1823 Enrollment Fee Payment Processing

Revision 13-4; Effective October 1, 2013

CHIP

Enrollment fee payments can be submitted in one of the following ways.

Method of Payment at Initial Enrollment:

- money order,
- personal check (not valid if original payment is non-sufficient funds),
- cashier's check, or
- credit card via www.yourtexasbenefits.com.

Method of Payment at Redetermination:

- money order,
- personal check,
- cashier's check, or
- credit card via www.yourtexasbenefits.com.

Payment for enrollment must be received and processed before cutoff prior to the last month of current CHIP certification.

The vendor receives all payments made to the program via money order, personal check or cashier's check. The vendor scans images and processes the payments. If the household mistakenly sends the payment to the Document Processing Center (DPC), the DPC logs the receipt of the payment and forwards the payment to the vendor for normal processing.

Enrollment fees submitted via www.yourtexasbenefits.com are charged a $2 non-refundable convenience fee. The household is mailed an electronic receipt.

D—1824 Refunds

Revision 13-4; Effective October 1, 2013

CHIP

Households that overpay the enrollment fee can request a refund. In addition, refunds are sent to households that submit the enrollment fee, but are never enrolled or have credit balances due at the time of disenrollment from the program. **Note:** Households enrolled in CHIP are not eligible for a refund if the household received at least one month of CHIP coverage and was required to pay an enrollment fee.

The Enrollment Broker issues a refund in Form of an individual check to the household, regardless of how the household made the payment. If the household pays by credit card, the $2 convenience fee is not refunded. Undeliverable refund checks are returned and voided. The vendor annotates the CHIP case and makes the necessary adjustment to the case to reflect the returned and voided refund. Once a refund is voided and processed, households may request reissuance of a voided refund. The vendor confirms the correct address with the individual before reissuing the previously voided refund.

D-1830, Copayment Requirements

Body

Revision 18-4; Effective October 1, 2018

CHIP

Households are required to pay copayments for medical services or prescription drugs at the time of the service. The applicable copayment requirements are:

Coverage Description	At or below 151% FPIL	Above 151% up to and including 186% FPIL	Above 186% up to and including 201% FPIL
Preventative health care and shots	$0	$0	$0
Non-emergency ER visit	$5	$75	$75
Generic prescription	$0	$10	$10
Name-brand prescription	$5	$35	$35
Inpatient hospital care (per admission)	$35	$75	$125
Outpatient hospital care	$0	$0	$0
Other doctor visits	$5	$20	$25

D-1840, Cost Sharing Cap Amounts

Body

Revision 18-4; Effective October 1, 2018

CHIP

The cost-sharing cap is the maximum amount of out-of-pocket expenses a household is required to pay during the certification period. When a household reaches its cost-sharing cap during the certification period, the household is not required to make copayments for the remainder of the certification period. Households are assigned a cost-sharing cap and a reporting threshold at application and at each redetermination. The reporting threshold is the amount in expenditures the household must report to the enrollment broker. The threshold is a cushion to ensure additional cost-sharing expenditures are not made during the period the enrollment broker and the health plan process the documentation.

The cost-sharing cap amount and reporting threshold are based on the household's net income as it relates to the FPIL amount.

The cost-sharing cap is 5.0% of the total net income for the term of coverage. The reporting threshold is 4.75%.

The household is informed of the reporting threshold and sent a medical payments form (MPF) with the welcome letter and enrollment packet. The MPF helps the family track medical expenditures by type, date and amount.

D—1841 Cost Sharing Processing

Revision 20-4; Effective October 1, 2020

CHIP

The household must complete and submit the MPF to report that it meets the cost sharing cap.

When the MPF is submitted, the Enrollment Broker reviews the types of expenses listed on Form. The household is not required to provide receipts. Valid medical expenses include:

- enrollment fees, if applicable;
- office visit copayments;
- prescription medicines;
- emergency room visits;
- inpatient or outpatient hospital care; and
- out-of-pocket expenses, such as dental or vision.

The Enrollment Broker reviews the amounts and dates of the expenses to ensure that the household incurred the expenses during the current certification period.

If the household meets the cost sharing cap, a Cost Share Met (CSM) letter is sent to inform the household that it is exempt from copayments for the remainder of the current certification period. The Enrollment Broker notifies the affected health plan within two business days. The health plan is responsible for issuing a new identification card reflecting the absence of copayments.

If the household does not meet the cost sharing cap, the Enrollment Broker triggers a Cost Share Not Met (CSN) letter to inform the household that the cost sharing limit was not met. The following situations may cause the household not to meet the cost sharing cap:

- invalid expenses;
- expenses incurred outside the current certification period;

- valid expenses, but the dates and amounts are blank; or
- the total amount listed on the form is less that the cost sharing cap/threshold.

The CSN includes the cost sharing limit and the total amount of valid expenses submitted. An MPF is included with the CSN.

D—1842 Cost Sharing Re-Evaluation

Revision 13-4; Effective October 1, 2013

CHIP

The household's cost sharing is re-evaluated at redetermination and the six-month income check.

For children who are currently enrolled, the Enrollment Broker does not use new income for eligibility determination.

The Enrollment Broker determines if all information is present to complete the evaluation at the six-month income check. If the income verification is not received and the reported income:

- increases, the Enrollment Broker recalculates the cost sharing for the household. A Cost Sharing Recalculation (CSC) letter is sent to inform the household that the change was complete and provides the household with the new cost sharing amount.
- decreases, a cost sharing re-evaluation is not processed. The Enrollment Broker sends a CSC No Change letter to inform the household that there is no change to the family's cost sharing obligation.

When no information is missing, the Enrollment Broker uses the new income reported during the six-month income check to determine if there has been a change in the household's cost sharing amount.

D-1900, Complaints and Request for Review

D-1910, CHIP Complaint Process

Body

Revision 16-2; Effective April 1, 2016

CHIP, CHIP Perinatal

Households may call 2-1-1 to report complaints regarding:

- a delay in processing a CHIP application,
- rude treatment by customer service staff,
- a gap in coverage after Medicaid denial, or
- the income used to determine the household's enrollment fee.

To report a delay in the CHIP enrollment process or complaints regarding plan selection, cost sharing and/or amount of the enrollment fee, households may contact the Enrollment Broker at 1-800-964-2777.

If a household is not satisfied with the response it received, the household must submit the issues in writing to:

Health and Human Services Commission
Attention: Complaint Department
P.O. Box 149027
Austin, TX 78714-9027

D-1920, Request for Review

Body

Revision 20-4; Effective October 1, 2020

CHIP and CHIP Perinatal

A request for review (RFR) is any expression of dissatisfaction with an adverse action taken by HHSC.

Following an adverse action taken on a CHIP EDG, HHSC sends a disenrollment or denial letter to the family. The letter informs the CHIP household of its right to request a review.

Households have 30 business days from the date of Form TF0001, Notice of Case Action, to submit a written request for review concerning the decision that resulted in an adverse action. Households can submit the written request for review by:

- faxing the request to 866-559-9628; or
- mailing the request to:
  - Texas Health and Human Services Commission
    P.O. Box 149027
    Austin, TX 78714-9027

The request must come from the head of household or authorized representative or the child's provider or health plan (for expedited situations). If the child's physician or health plan determines that a suspension or termination of enrollment could seriously jeopardize the child's life, health or the ability to attain, maintain or regain maximum function, the household is entitled to an expedited review process. When disenrolled at the six-month income check, the household has 30 business days from the date of Form TF0001 to submit a request for review.

Allow continued enrollment for all people when HHSC receives the request for review anytime from the first day of the last benefit month through cutoff of the last benefit month.

Exception: A household is not eligible for continued enrollment if the household was denied for failure to provide information requested during a six-month income check.

Related Policy

Six-Month Income Check, D-1500
Exceptions to the Continuous Enrollment Period, D-1731

D—1921 Request for Review Processing

Revision 20-4; Effective October 1, 2020

CHIP and CHIP Perinatal

If any member of a household or the household's representative expresses dissatisfaction with a decision regarding benefits or services, take the following action:

- explain the basis for the decision and the applicable policies;
- provide the household an opportunity to have a conference with the supervisor;
- provide the household an opportunity to request a review; and
- consult with the supervisor if the person requests information considered confidential.

Note: The member is entitled to any information used to determine suspension, reduction or termination of benefits. See B-1210, Disclosure of Information, for information considered confidential.

Upon receipt of the request for review, review the adverse action and send Form H1063, Request for Review Outcome Letter, within 10 business days from the date of receipt of the request. The response letter contains information addressing the answer to the request for review. Document the final decision.

When the request for review is received, validate that the person requesting the review has case authority.

- If a person with case authority requests the review in writing, request-for-review staff review all case information and supporting evidence that the household provides. Make a determination and send Form H1063 informing the household of the decision.
- If the person requesting the review does not have case authority, deny the request and send Form H1063 to inform the household of the request for review denial.

Review all case information and supporting evidence the household provides. If the case was processed accurately, deny the request for review. Send Form H1063 to inform the household of the request for review outcome.

If the EDG was not processed accurately or the person submitted additional information with the request for review that changes the eligibility outcome, approve the request for review and take the necessary action to re-establish eligibility or enrollment. Send Form H1063 and Form

TF0001, Notice of Case Action, to inform the household of its eligibility.

When the request for review is approved and the reason for the request is related to a disenrollment decision, review the child's current status to determine if the child is currently enrolled. If the child is:

- currently enrolled, advise the Enrollment Broker to cancel the disenrollment for the future month to ensure the child's enrollment continues through the end of the current enrollment period and generate Form H1063. In addition, the Enrollment Broker will send an Enrollment Confirmation Notice.
- not enrolled due to renewal period ending adversely, request-for-review staff process the CHIP eligibility and send Form H1063 and Form TF0001 to inform the household of CHIP eligibility. The Enrollment Broker re-enrolls the child for another 12-month period and once enrollment is re-established, the Enrollment Broker will send an Enrollment Confirmation Notice.

When HHSC receives a request for review after 30 business days from the date of Form TF0001 or determines that the request for review is not for an adverse action, deny the request and generate Form H1063 to inform the household of the denial reason.

D-2000, Confidentiality

D-2010, General Policy

Body

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Eligibility Determination Group (EDG) information may be released to individuals who have case authority.

A CHIP or CHIP perinatal household member may give verbal permission to discuss their case with a third party. Staff must authenticate the CHIP or CHIP perinatal household member before discussing the case with a third party.

Limited information may be released to contracted organizations, providers and their contractors, public officials and other state agencies. Reasonable efforts must be made to limit the use, request or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and operate the program. The disclosure of individual medical information from agency records must be limited to the minimum necessary to accomplish the requested disclosure.

It is acceptable to release the following general denial or disenrollment reasons.

- Failure to provide missing Information
- Voluntary withdrawal

It is unacceptable to provide specific EDG details, such as the specific reason for denial (excess assets, excess income).

D—2011 Community Based Organizations

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Limited information may be released to contracted or sub-contracted community-based organization (CBO) representatives. The CBO representative must provide the CBO identification number in order to receive EDG information. In addition, the CBO representative must provide the:

- name of the head of household,
- address, and
- child's Social Security number (SSN).

Staff may then release the following CHIP EDG information to the CBO:

- status of the application or EDG (denied, disenrolled, enrolled, missing information),
- missing information on an EDG (types of information needed to complete eligibility determination),
- enrollment coverage dates (start and end dates), and
- enrollment fee amount.

Do not release specific EDG details, such as:

- the reason for denial,
- sources or amounts of income,
- types of assets,
- household size, and
- citizenship/alien status.

D—2012 Providers and Health Plans

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Limited information may be released to providers and health plans. Health care providers must give their provider identification number. If a provider participates with more than one CHIP health plan, the provider may have multiple identification numbers. Accept and document any identification number the provider gives.

The provider or health plan must confirm the:

- name of the head of household,
- address, and
- child's Social Security number (SSN).

Staff may then release the following EDG information to the provider or health plan:

- status of the application or EDG (denied, disenrolled, enrolled, missing information);
- missing information on an EDG (types of information needed to complete eligibility determination);
- enrollment coverage dates (start and end dates); and
- other EDG information as requested (enrollment fee, cost share limit, copayments).

D—2013 Federal and State Executive and Legislative Officials

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Limited information may be released to federal and state executive and legislative branch members and their staff. Managers and supervisors may release to State of Texas legislators and legislative staff members the following information:

- Case or EDG eligibility status
- Missing information on an application or EDG
- Enrollment coverage dates
- Enrollment status
- Enrollment fee amount

D—2014 Teacher Retirement System (TRS)

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Limited information may be released to TRS representatives. In order to obtain any EDG information, the representative must provide the assigned TRS personal identification number and any of the following CHIP EDG information:

- Case or EDG number
- Name of the person with case authority
- Home telephone number
- Child's name
- Child's Social Security number

Staff may then release the following EDG information to the TRS representative:

- status of the application or EDG (denied, disenrolled, enrolled, missing information);
- missing information on a EDG (types of information needed to complete eligibility determination);
- enrollment coverage dates (start and end dates); and
- other EDG information as requested (enrollment fee, cost share limit, copayments).

D-2020, Health Insurance and Portability Accountability Act

Body

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Policies and procedures have been established for the secure communication of Protected Health Information (PHI) or confidential information to ensure employees do not use or share any PHI in violation of HIPAA laws and standards. Unauthorized disclosure of PHI is grounds for disciplinary action.

When sharing information is appropriate, HIPAA allows staff to speak to the individual or others with case authority about PHI.

Calls received by the Customer Care Center staff are recorded, which safeguards PHI. These records keep track of who has accessed a recipient's information. Requests from recipients for copies of their records, corrections to mistakes in records and information pertaining to who has accessed the records are forwarded to HHSC.

D-2100, Reserved for Future Use

D-2200, Reserved for Future Use

D-2300, Forms

Body

Revision 15-4; Effective: October 1, 2015

CHIP, CHIP Perinatal

The Enrollment Broker must ensure that individual correspondence is clear, concise and has been approved by the Texas Health and Human Services Commission (HHSC).

Acronym/Form	Title	Description
CBL	Charge Back Letter	Sent to notify an individual that the individual's credit card was charged more than once for the enrollment fees and that the individual will need to contact the credit card company or bank to get a refund.
CSC	Cost Share Recalculation	Sent when a household submits new income information and its cost share is re-evaluated.
CSM	Cost Share Met	Sent to notify an applicant that the cost share has been met.
CSN	Cost Share Not Met	Sent to notify a household that the cost share has not been met.
DTF	Dental Enrollment Transfer Form	Captures dental plan selections.
E1R	Enrollment Reminder	Sent to remind the applicant that the enrollment form and/or enrollment fee has not been received.
ECN	Enrollment Confirmation Notice	Sent to confirm enrollment for new enrollees and at redetermination. It also informs the applicant of their cost share amount.
EFX	Enrollment Fee Extension Letter	Sent to households who have completed their Children's Health Insurance Program (CHIP) redetermination process completely by cutoff of the 12th month of their current coverage, but who have not paid the enrollment fee. The letter tells the household they have until cutoff of their first month of new coverage to pay this fee.
EMI	Enrollment Missing Information	Sent to notify the applicant that the enrollment form was either missing, incomplete or was received without the entire enrollment fee amount due.
EPM	Welcome Letter	Sent with the new enrollment packet. The child is pending eligibility for enrollment and enrollment fee, if not entered.
ETF	Enrollment Transfer Form	Captures health plan and primary care physician (PCP) selections along with special health care needs.

Acronym/Form	Title	Description
FEF	Form Request – Enrollment Transfer Form (medical and dental)	Sent when an individual requests a new ETF and/or DTF.
FPB	Form Request – Medical Payment Form (blank)	Sent when an individual requests a blank Medical Payments Form (MPF).
FPC	Form Request – Medical Payment Coupon	Sent when an individual requests a new Payment Coupon (MPC).
FPF	Form Request – Medical Payment Form (prepopulated)	Sent when an individual requests a new prepopulated MPF.
FPR	Form Request – All Forms (ETF, DTF, MPC, Blank MPC)	Sent when an individual requests a new copy of any combination of ETF, DTF, MPC, prepopulated MPF and/or blank MPF.
HCC	Health Plan Transfer Letter	Sent to notify the applicant of the completion of either a forced or requested plan transfer.
HPC	Health/Dental Plan Transfer Approval Letter	Sent to notify the applicant of the individual's authorization to make a plan transfer.
HPD	Health Plan Change Denial Letter	Sent to notify the applicant that the individual's transfer request was denied.
LPD	Last Payment Due Reminder Letter	Sent to inform the applicant their enrollment fee has not been received, and the final day it can be paid
MPC	Payment Coupon	Coupon requesting that the household pay its enrollment fee.
MPF	Medical Payments Form	Used by the individual to track all copay cost sharing so that the individual can report it.
NSF	Non-Sufficient Funds	Sent to notify an individual that a payment was returned for non-sufficient funds. The letter instructs the individual on how to make a new payment.
PHL	Payment History Letter	Letter that provides a listing of payments made during a specified time period. The letter is manually printed and mailed to the individual by the Enrollment Broker Funds team.
PNL	Payment Not Needed	Sent to inform an individual that a payment is being returned to the household because the household does not owe any payments at this time or the payment is unable to be processed.
POD Cover Letter	Print on Demand Cover Letter	Cover letter sent when a client requests a copy of the letter that had previously been sent to the individual.
RAC	Refund Address Confirmation	Sent to a CHIP household that qualifies for a refund in order to confirm the household's current mailing address. The letter is generated when the household is owed a refund and a current phone number does not exist in the case or when the customer care representative is unable to reach the household using the existing phone listed in the case.
RNL	Retro Notification Letter	Sent to inform an individual that the enrollment start date for their children has changed.
UPR	Unclaimed Property Letter	Sent to a participant of CHIP or the Medicaid Buy-In (MBI) program who is owed a refund of $250 or more for a closed Eligibility Determination Group (EDG) and who has had no account activity for at least three years. The letter is generated on a yearly basis.

D-2400, Glossary

D-2410, Glossary Listing

Body

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Advance Notice — A notice of adverse action that expires 13 days after it is sent, with the exception of a six-month income check. Households denied at a six-month income check are given a 30-day advance notice of adverse action.

Adverse Action — An action resulting in denial or termination of assistance.

Applicant — An individual who submits an application to apply for assistance.

Case Authority — An individual who has the authority to act on behalf of the child. Examples include parents who live with the child, grandparents who live with the child, spouse, independent child, payee or authorized representative.

Children's Insurance — Includes Children's Medicaid and Children's Health Insurance Program (CHIP).

Community Based Organization (CBO) — Organization providing assistance to an applicant applying for and enrolling in state-funded programs by aiding in the application process and seeking answers to case inquiries.

Disenrollment — The process by which a child's CHIP coverage is removed.

Enrollment — The process by which a child's CHIP coverage begins.

Enrollment Broker – Entity that enrolls an eligible child into CHIP or an eligible pregnant woman into CHIP perinatal once health and dental plan selections have been made and any required enrollment fees have been paid.

Enrollment Missing Information — Required information needed to complete the enrollment process that includes choosing a health plan and paying an enrollment fee.

Net Income — Gross income less the allowable child care deduction.

Perinate — An individual from the period of conception to birth. The unborn child.

Plan Partners — Organizations contracted through HHSC to provide health, dental or vision care services to CHIP enrolled children.

Request for Review — A written expression of dissatisfaction of an adverse action taken on a CHIP case. CHIP recipients are not allowed fair hearings.

Part E, Former Foster Care Children

E-100, Application Processing

E-110, Medicaid for Former Foster Care Children (FFCC)

Body

Revision 24-2; Effective April 1, 2024

The following, commonly referred to together as the Affordable Care Act (ACA), require states to extend Medicaid coverage to the population of youth who are between 18 and 26 and aged out of foster care at 18 or older.

- the Patient Protection and Affordable Care Act (Public Law 111-148); and
- the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, requires states to extend Medicaid coverage to youth who transitioned out of foster care in a state other than Texas if:

- they turned 18 on or after Jan. 1, 2023; and
- were receiving federally funded Medicaid when they aged out.

Before Jan. 1, 2023, to be eligible for FFCC, a person must have aged out of foster care in the state of Texas at 18 or older while receiving Medicaid.

Note: A person who aged out of foster care in the state of Texas at 18 or older while receiving Medicaid is still eligible regardless of the year.

The Texas Health and Human Services Commission (HHSC) coordinates with the Texas Department of Family and Protective Services (DFPS), which administers the foster care program, to provide coverage to this population. When a child ages out of foster care, Medicaid eligibility for these youths is transferred from Foster Care Medicaid to Former Foster Care Medicaid (FFCC). DFPS certifies initial FFCC eligibility for youth aging out of foster care and HHSC is then responsible for determining their future Medicaid eligibility.

Note: There may be situations that HHSC processes the initial certification.

E—111 Type of Assistance (TA) 82 – Medical Assistance – FFCC

Revision 24-2; Effective April 1, 2024

To be eligible for FFCC, a person must be 18 to 26 and:

- have aged out of foster care in any state at 18 or older;
  Note: A person who turned 18 before Jan. 1, 2023, must have aged out of foster care in the state of Texas.
- received federally funded Medicaid when they aged out of foster care; and
- meet all other Medicaid eligibility criteria, including Texas residency and U.S. citizenship or alien status.

Specialized staff process all FFCC case actions.

Related Policy

Verification Requirements, E-140

E—112 Application Processing

Revision 24-2; Effective April 1, 2024

Centralized Benefit Services (CBS) receives:

- a new FFCC case or Eligibility Determination Group (EDG) by an interface with the Texas Department of Family and Protective Services (DFPS); or
- an application completed by a person who aged out of foster care.

CBS staff are notified by DFPS or HHSC Quality Assurance when a referral or interface is not completed. In cases where a DFPS referral or interface is not completed, CBS staff contact DFPS to determine the reason and confirm if eligibility criteria is met for FFCC. If the person meets the eligibility criteria, CBS staff certify the person for FFCC without requiring an application.

There are instances when a person is denied ongoing FFCC coverage and must submit a new application for benefits. FFCC coverage may be denied if the person:

- voluntary withdraws;
- moves out of state; or
- fails to return verification during a renewal.

A person denied ongoing FFCC benefits may experience gaps in coverage. When there is a gap in coverage, the person must apply using any of the Medical Programs application channels.

The following question must be marked **Yes** on the application for eligibility to be considered for FFCC.

- Were you in foster care at 18 or older?

If the FFCC question is marked yes, the following questions must also be answered.

- If yes, who?
- In which state?

If the person turned 18 on or after Jan. 1, 2023 and aged out of foster care in a state other than Texas, verify the person's former foster care status and Medicaid enrollment status from the other state.

Follow the steps below to locate the out-of-state agency contact information and make collateral call(s) to verify former foster care and Medicaid enrollment statuses for youth who aged out of foster care on or after Jan. 1, 2023.

1. Enter the following link in a web browser: https://www.medicaid.gov/about-us/contact-us/index.html.
2. Select the appropriate state from the "Contact Your State Medicaid Agency" drop-down and then select "go".
3. Identify the best contact number and attempt to make collateral call(s) to get verification. If collateral call is:
   a. Successful, answer the former foster care related question in the Individual – Individual Information LUW in TIERS, select "contacted out of state agency" as the verification source in the new "Verification of Medicaid Enrollment" drop down, and document the state agency contact person's name, phone number and any other information in the mandatory text box field.
   b. Unsuccessful, answer the former foster care related questions in the Individual – Individual Information LUW in TIERS, select "Not Verified" in the new "Verification of Medicaid Enrollment" drop down. Send Form H1020, Request for Information or Action.
4. Document any failed collateral call attempts in Case Comments.

Note: Follow the current policy when an applicant recently received benefits in another state, including verifying the last month the benefits were issued.

If ineligible for FFCC, the person will be considered for eligibility under other Medical Programs.

Related Policy

Application Requests and Submissions, A-113
New Texas Residents, A-720
Type of Assistance (TA) 82 - Medical Assistance - FFCC, E-111
Verification Sources, E-140

E—113 Requesting an Application

Revision 15-4; Effective October 1, 2015

Applicants may request to apply for FFCC as explained in A-113, Application Requests and Submissions.

Related Policy

Registering to Vote, A-1521

E—114 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

An individual may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

E-120, Office Procedures

Body

E—121 Filing an Application

Revision 17-1; Effective January 1, 2017

individuals who wish to apply for FFCC, can;

- submit an application as explained in A-113, Application Requests and Submissions; and
- sign an application as explained in A-121, Application Signature.

E—122 File Date

Revision 20-4; Effective October 1, 2020

The file date is the day an application is received in one of the following ways:

- by an HHSC eligibility determination office;
- online through YourTexasBenefits.com;
- by phone through 2-1-1; or
- through an account transfer from the Marketplace.

The file date for cases received through the DFPS interface is the date HHSC receives the interface. To be a valid application, it must contain the applicant's name, address, and appropriate signature/electronic signature. The day of receipt is day zero in the application process.

Document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on the application; or
- the application has two received dates (stamp dates).

Note: For applications received outside of normal business hours, the file date is the next business day.

Related Policy

Application Signature, A-122.1

E-130, Interviews

Body

E—131 General Policy

Revision 15-4; Effective October 1, 2015

An interview is not required when applying for or renewing an application for the FFCC program. Schedule a phone interview only if the individual requests an interview. The State Portal Scheduler does not support scheduling for the FFCC program. Any requests for an interview must be scheduled manually.

Note: Advisors must continue determining eligibility, rather than denying the application, if the applicant misses the interview.

E-140, Verification Requirements

Body

Revision 24-2; Effective April 1, 2024

Verify a person's former foster care status and Medicaid enrollment status if the person:

- aged out of foster care at 18 or older in another state; and
- turned 18 on or after Jan. 1, 2023.

E-141 Verification Sources

Revision 24-2; Effective April 1, 2024

Verify Medicaid eligibility using the following verification sources:

- official form, notice or statement from the out-of-state foster care agency;
- court order; or
- contact with out-of-state agency.

Use the out-of-state agency contact information linked here.

Related Policy

Documentation Requirements, E-150

E-150, Documentation Requirements

Body

Revision 24-2; Effective April 1, 2024

Successful Collateral Call

Document the details of the collateral call to the out-of-state agency contact. Include the person's name, phone number and other relevant information in the mandatory text box populated in the Texas Integrated Eligibility Redesign System (TIERS) Individual – Individual Information logical unit of work (LUW).

Unsuccessful Collateral Call(s)

Document the details of any unsuccessful collateral call attempts in the case record.

E-200, Household Composition

E-210, General Policy

Body

Revision 15-4; Effective October 1, 2015

The certified group consists of only the individual.

E-220, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

There are no verification requirements for household composition. Advisors must accept the individual's statement as verification.

E-300, Citizenship

E-310, General Policy

Body

Revision 15-4; Effective October 1, 2015

Verify citizenship and alien status following the Medical Programs policy for citizenship and alien status eligibility in A-300, Citizenship. Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for Medicaid for Former Foster Care Children (FFCC) if they meet all other eligibility criteria.

The alien status policy for FFCC follows Chart D in Section A-342, TANF and Medical Programs Alien Status Eligibility Charts. Individuals are no longer eligible for FFCC the month after their 21st birthday if they no longer qualify under Chart D. For individuals age 21 and older, continue eligibility if they are otherwise eligible based on Charts A, B, and C.

Allow applicants and recipients a period of reasonable opportunity, if applicable, to verify their citizenship or alien status, as explained in A-351.1, Reasonable Opportunity.

E-320, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

The Texas Department of Family and Protective Services (DFPS) interface provides the following information pre-populated into the Texas Integrated Eligibility Redesign System (TIERS) for individuals with an alien status:

- Document Type — I-551 orI-94
- Annotation/Category (conditionally based on documenttype)
- U.S. Citizenship and Immigration Services (USCIS) Documented US EntryDate
- Alien Status ExpirationDate
- Alien Registration Number (the “A”number)

Verification of alien status is required when the information received via the interface does not match the information in TIERS or when the document type is marked "other." Do not request verification from the individual until efforts to verify alien status through DFPS have been attempted. Staff must request an image of the alien status documentation from DFPS to verify the alien status.

Within 10 days of receiving the task, staff must email the DFPS FC-ADO mailbox at fcadomedex@dfps.state.tx.us and copy tonya.eason@dfps.state.tx.us to request the image of the alien documentation. The email must include the individual's name, date of birth, and Social Security number (SSN) and must be encrypted. **Do not** include any client information in the subject line of the email. DFPS should reply to this request within five workdays.

If the DFPS image does not provide sufficient information to verify alien status, then FFCC applicants must receive a period of reasonable opportunity, explained in A-351.1, Reasonable Opportunity, to verify their alien status.

E-400, Social Security Number

E-410, General Policy

Body

Revision 20-2; Effective April 1, 2020

All applicants must provide a Social Security number (SSN) or apply for one through the Social Security Administration (SSA) before certification.

The Former Foster Care Children (FFCC) program follows the SSN policy in A-400, Social Security Number, under the All Programs or Medical Programs headings.

E-500, Age

E-510, General Policy

Body

Revision 15-4; Effective October 1, 2015

Applicants are eligible to receive Medicaid for Former Foster Care Children (FFCC) benefits from age 18 through the month of their 26th birthday.

Exception: An individual is no longer eligible for FFCC the month after the individual's 21st birthday if the individual no longer qualifies due to alien status, as explained in E-310, General Policy.

E-520, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

Advisors accept self-declaration as verification of age.

E-530, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

Document the individual's self-declaration establishing the age.

E-600, Relationship

Body

Revision 15-4; Effective October 1, 2015

Relationship requirements are not applicable in the Former Foster Care Children (FFCC) program.

E-700, Identity

E-710, General Policy

Body

Revision 15-4; Effective October 1, 2015

To establish identity, follow Medical Programs policy in A-600, Identity.

E-800, Residence

Body

Revision 23-3; Effective July 1, 2023

Follow Children's Medicaid policy to determine residence eligibility.

Related Policy

Residence, A-700

E-810, General Policy

Body

E—810 General Policy

Revision 15-4; Effective October 1, 2015

To determine residence eligibility, follow the Medical Programs policy in A-700, Residence.

E-900, Adequate Health Coverage (Third-Party Resource)

E-910, General Policy

Body

Revision 15-4; Effective October 1, 2015

Former Foster Care Children (FFCC) recipients may have adequate health coverage. Adequate health coverage is also known as a third-party resource (TPR). FFCC follows TPR policy in A-860, Third-Party Resources (TPR). FFCC recipients with TPR must cooperate in providing details of the TPR.

E-920, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

The TPR information has been verified when the "NHIC" box is checked and greyed out. Staff cannot end/terminate the coverage. If the individual has TPR and the "NHIC" box is greyed out, this information has already been verified by the Office of Inspector General – Third Party Liability area.

Request verification if:

- the individual indicates the individual has TPR, and
- required TPR information has not been verified.

Some former foster care individuals' parents may have TPR coverage for the applicant without the individual being aware of this coverage. If the individual states they are not aware of the TPR or do not know the details of the TPR, but the TPR has been verified by the claims administrator, advise the applicant to call the claims administrator's Third Party Liability Customer Service Line at 1-800-846-7307 and select option 2. This will allow the individual to obtain information regarding the TPR.

If the TPR information in the Texas Integrated Eligibility Redesign System (TIERS) has been verified by the claims administrator but needs to be updated, fax the completed Form H1039, Medical Insurance Input, to the claims administrator at 512-514-4215.

E-1000, Medicaid Eligibility

E-1010, General Policy

Body

Revision 20-4; Effective October 1, 2020

To determine the correct eligibility begin dates, follow policy in A-820, Regular Medicaid Coverage. A person is continuously eligible beginning the first day of the application month if all eligibility criteria are met. Certified applicants are eligible to receive benefits beginning the month of their 18th birthday through the end of the month of their 26th birthday.

The Medical Effective Date (MED) cannot precede:

- Jan. 1, 2014, the program effective date; or
- the month of the person's 18th birthday.

Follow policy in B-500, Medical Coverage for Individuals Confined in a Public Institution, for people who are confined in a public institution.

Related Policy

Regular Medicaid Coverage, A-820
Medical Coverage for Individuals Confined in a Public Institution, B-500

E—1011 Three Months Prior Coverage

Revision 15-4; Effective October 1, 2015

Applicants for Medicaid for Former Foster Care Children (FFCC) are eligible for three months prior coverage.

Three months prior coverage under FFCC cannot precede January 1, 2014. If eligible under another Medicaid program, an individual can receive three months prior coverage for months requested prior to January 1, 2014, on the Medicaid program for which the individual would have qualified prior to January 1, 2014. Coverage from January 1, 2014, forward will be under the FFCC program.

E—1012 Types of Coverage

Revision 18-1; Effective January 1, 2018

FFCC recipients are automatically enrolled in STAR Health through the month of their 21st birthday. STAR Health provides a full range of Medicaid-covered medical and behavioral health services for Texas Department of Family and Protective Services (DFPS) individuals. Individuals may opt out of STAR Health for STAR, which allows for a choice of health plans.

People under age 21 who receive Supplemental Security Income (SSI) or reside in a nursing facility have the choice of staying in STAR Health or opting into STAR Kids if they meet one of the following criteria:

- receive Medicaid and Medicare; or
- receive services under one of the following 1915(c) waiver programs:
  - Home and Community-based Services (HCS);
  - Community Living Assistance and Support Services (CLASS);
  - Texas Home Living (TxHmL);
  - Deaf Blind with Multiple Disabilities (DBMD);
  - Medically Dependent Children Program (MDCP); or
  - Youth Empowerment Services (YES).

Once an FFCC recipient attains age 21, coverage will transfer to STAR. STAR provides a full range of Medicaid-covered medical and other services for many children and adults. **Exception**: Individuals ages 21 up to age 26 who meet the STAR+PLUS criteria must enroll in the STAR+PLUS managed care program.

Related Policy

Managed Care, A-821.2
Managed Care Plans, C-1116

E-1100, Domicile

Body

Revision 15-4; Effective October 1, 2015

Domicile requirements do not apply to the Former Foster Care Children (FFCC) program.

E-1200, Deprivation

Body

Revision 15-4; Effective October 1, 2015

Deprivation requirements do not apply to the Former Foster Care Children (FFCC) program.

E-1300, Child Support

Body

Revision 15-4; Effective October 1, 2015

Child and medical support requirements do not apply to the Former Foster Care Children (FFCC) program.

E-1400, Resources

Body

Revision 15-4; Effective October 1, 2015

Resources are not considered as a factor in determining eligibility for the Former Foster Care Children (FFCC) program.

E-1500, Income

Body

Revision 15-4; Effective October 1, 2015

Income is not considered as a factor in determining eligibility for the Former Foster Care Children (FFCC) program.

E-1600, Deductions

Body

Revision 15-4; Effective October 1, 2015

Since there is no income test, deductions are not considered as a factor in determining eligibility for the Former Foster Care Children (FFCC) program.

E-1700, School Enrollment

Body

Revision 15-4; Effective October 1, 2015

School attendance requirements do not apply to the Former Foster Care Children (FFCC) program.

E-1800, Management

Body

Revision 15-4; Effective October 1, 2015

Management requirements do not apply to the Former Foster Care Children (FFCC) program.

E-1900, Reminders

E-1910, General Policy

Body

Revision 15-4; Effective October 1, 2015

Before certifying applicants and recertifying recipients, advisors must:

- Ensure the applicant completes each question and signs and dates the application.
- Give the applicant Form H1019, Report of Change. Explain that changes must be reported within 10 days after knowing about the change. Indicate the appropriate reporting requirement on Page 1.
- Refer the applicant to other programs the individual might be eligible for such as the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Medicaid; Supplemental Security Income (SSI); or Retirement, Survivors and Disability Insurance (RSDI). Refer individuals with a disability who are ineligible for Medical Programs for families and children to the Texas Health and Human Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) programs.
- Inform the applicant of the right to appeal any HHSC action that affects the individual's eligibility.
- Inform the applicant that the information the applicant provides is subject to verification by third parties.

E-1920, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

Advisors must document that form VR30, Texas Voter Registration Application, was given to the applicant, authorized representative or representative payee in the Agency Use Only section of the application.

Related Policy

Registering to Vote, A-1521

E-2000, Case Disposition

Body

E—2010 Notice to Applicants

Revision 15-4; Effective October 1, 2015

When processing an application, redetermination or change, advisors are required to inform the individual if their request is pended, certified, sustained, or denied. Eligibility Determination Group (EDG) disposition is the end result of processing the request for assistance and will generate Form TF0001, Notice of Case Action. However, if the EDG cannot be disposed because it is pending for additional information/verification, the advisor must provide the individual with Form H1020, Request for Information or Action.

Form H1020, Request for Information or Action

Form H1020 informs the individual the:

- reason the case is pending;
- action the individual or advisor must take;
- date by which the individual or advisor must take action; and
- date the advisor must deny the application/case if the individual does not take action, if applicable.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

Form TF0001, Notice of Case Action

Form TF0001 informs the individual:

- the date benefits begin,
- the date of denial and right to a fair hearing to appeal a case action, and
- address and telephone number of free legal services available in the area.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

E—2020 Length of Certification

Revision 25-1; Effective Jan. 1, 2025

The eligibility determination system calculates the eligibility end date from the date staff dispose the EDG as follows:

- Applications — initial certification month plus 11 months.
- Renewals — 12 months from the last certification month.

Recipients are continuously eligible for Former Foster Care Children (FFCC) benefits for 12 months or through the month of their 26th birthday, whichever is earlier.

Exception: A recipient is not eligible to receive 12 months of continuous eligibility if they:

- reach 26 years;
- die;
- voluntarily withdraw; or
- move out-of-state.

Note: A FFCC recipient remains on FFCC after a report of pregnancy. If the recipient's FFCC coverage is denied, including if she ages out of the program, she is transitioned to Medicaid for Pregnant Women (TP 40) for the rest of her pregnancy and 12-month postpartum period.

E—2030 Setting Special Reviews

Revision 15-4; Effective October 1, 2015

Use Medical Programs policy in A-2330, Setting Special Reviews, to set special reviews.

E—2040 Adverse Action

Revision 15-4; Effective October 1, 2015

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations, households may continue receiving benefits pending an appeal. After certification, advisors give households advance notice of adverse actions to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

For adverse action, advisors use current policy in A-2340, Adverse Action.

E-2100, Processing Time Frames

E-2110, Applications

Body

Revision 15-4; Effective October 1, 2015

Advisors must make an eligibility determination by the 45th day from the file date.

Reopen an application denied for failing to furnish information/verification if the missing information is provided by the 60th day from the file date. Use the date the missing information/verification was provided as the new file date.

Use the original application, until it is 60 days old.

If the information on the form has changed or is more than 45 days old, the individual and advisor must update the form.

E-2120, Deadlines

Body

Revision 15-4; Effective October 1, 2015

Provide Form TF0001, Notice of Case Action, the same day eligibility is determined for an application but no later than 45 days from the file date.

E-2130, Missed Interviews

Body

Revision 15-4; Effective October 1, 2015

No interview is required to process an application or renewal unless requested by the applicant/individual. If an interview is requested, advisors provide the applicant/individual a telephone interview. If the individual fails to keep the interview, advisors must not deny the application or renewal but continue to process the request for assistance.

E-2140, Pending Information on Applications

Body

Revision 15-4; Effective October 1, 2015

Advisors may not request additional information or documentation from clients unless such information is not available electronically or the information obtained electronically is not consistent with the information provided by the client.

If additional information is needed, advisors must request documents that are readily available to the household and are considered to be sufficient verification. Each handbook section lists potential verification sources. C-900, Verification and Documentation, gives information on verification procedures.

In determining eligibility, advisors must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

E-2150, Notice of Renewal/Expiration

Body

Revision 15-4; Effective October 1, 2015

The system generates and sends renewal correspondence to individuals enrolled in Medicaid for Former Foster Care Children (FFCC) following the process explained in B-121, Notice of Redetermination/Certification Expiration, for TP 08 and Children's Medicaid (TP 43, TP 44 and TP 48).

Note: The system will generate Form H1206, Health Care Benefits Renewal - FFCC, rather than Form H1206, Health Care Benefits Renewal - MA, for individuals renewing FFCC.

E-2160, Processing Renewals

Body

E-2161 How to Process a Renewal

Revision 15-4; Effective October 1, 2015

FFCC completes an administrative renewal process. An administrative renewal is initiated by the system and requires no advisor action. The administrative renewal process uses the automated renewal process, explained in E-2161.1, Automated Renewal Process, to gather information from a client's existing case and from electronic data sources to determine whether the client remains potentially eligible for Medical Programs.

E-2161.1 Automated Renewal Process

Revision 15-4; Effective October 1, 2015

The automated renewal process is the first step in an administrative renewal. The automated renewal process runs the weekend before cutoff in the ninth month of the certification period and does not require advisor action.

The process uses electronic data to automatically:

- assess the verifications required by type program for renewals;
- determine the eligibility outcome; and
- send the renewal correspondence to the client.

E-2161.1.1 Verifications Required for Renewals

Revision 25-3; Effective July 1, 2025

Re-verify the certified alien's immigration status if their document expires before the next redetermination. The alien's immigration status does not require reverification if the USCIS documents have not expired.

E-2161.1.2 Eligibility Outcomes

Revision 15-4; Effective October 1, 2015

Once available verifications are assessed during the automated renewal process, the system runs eligibility. The following chart lists the possible eligibility outcomes of the automated renewal process.

Automated Renewal Process: Eligibility Outcomes

Eligibility Potentially Approved	• All required eligibility information **can** be verified during the automated renewal process and no additional verification is needed from the client. • Clients must review the information used to determine their eligibility. • Clients are only required to return a signed renewal Form H1206, Health Care Benefits Renewal - FFCC, if the information on the renewal form is incorrect or there are changes to the client's case.
Additional Information Needed	• All required eligibility information **cannot** be verified during the automated renewal process and additional verification is needed from the client. • The client must return a signed renewal form, Form H1206-FFCC, and all requested verification(s).

E-2161.1.3 Renewal Correspondence

Revision 15-4; Effective October 1, 2015

The system generates client correspondence according to the eligibility outcome of the automated renewal process and the action needed by the client.

The following chart lists the correspondence generated for each eligibility outcome of the automated renewal process and the required client response.

Automated Renewal Process: Renewal Correspondence

Eligibility Outcomes	Correspondence and Required Client Response
Eligibility Potentially Approved	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, notifies the client that they must review the information used to determine their eligibility on Form H1206, Health Care Benefits Renewal - FFCC. • The client is only required to return a signed renewal form, Form H1206 - FFCC, if the information on the form is incorrect or there are changes to the client's case. • Form M5017, Documents to Send with Your Renewal Application, is included with Form H1206. • No additional forms are sent with Form H1211.
Additional Information	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, and Form H1020, Request for Information or Action, are sent to the client.

Eligibility Outcomes	Correspondence and Required Client Response
Needed	• Form H1211 notifies the client that they must return the following: ◦ Signed renewal form, Form H1206 - FFCC; and ◦ Required verification(s). • Form H1020 identifies all the required verification(s) needed to complete the renewal and a statement that the signed renewal form is required. • Form M5017, Documents to Send with Your Renewal Application, is included with Form H1206 - FFCC.

Form TF0001, Notice of Case Action, is sent when a final eligibility determination has been made. Depending on the renewal status outcome and client action, final eligibility determinations may be made by advisors manually processing renewal documents or by the system automatically. Form TF0001 identifies the dates of the new certification period for Medicaid benefits or the denial reason for not recertifying the case.

E-2161.2 Processing a Manual Renewal

Revision 20-4; Effective October 1, 2020

If a person is required to return a renewal form and returns a paper Form H1206, Health Care Benefits Renewal - FFCC, the form is routed to CBS for processing. If an FFCC renewal is submitted to a local office, it may be processed by the local office advisor but only CBS staff may dispose the FFCC EDG. If an FFCC renewal needs to be disposed, a Task List Manager (TLM) task will be generated for CBS instructing them to dispose the renewal.

The file date is the day that any local eligibility determination office receives an acceptable FFCC renewal form. The following are considered acceptable FFCC forms:

- Form H1206, Health Care Benefits Renewal - FFCC
- Form H1010-R, Your Texas Works Benefits: Renewal Form

A redetermination is considered timely if a renewal form is received by the first calendar day of the 11th month of the certification period. A redetermination is considered untimely if a renewal form is received after the first calendar day of the 11th month of the certification period and through the last day of the 12th month.

Note: If the first calendar day of the 11th benefit month falls on a weekend or a holiday and the redetermination is received on the following business day, the redetermination is considered timely.

Process redeterminations, received timely or untimely, by the 30th day from the date the renewal form is received **or** by cutoff of the 12th month of the certification period, whichever is later.

When an acceptable FFCC renewal form is received, review the information provided and determine if the case needs to be updated to reflect the most recent information reported by the person on the form.

Only request information and verification needed to determine eligibility from the person when it is not available through electronic data sources. Verification previously provided must be used to renew eligibility when the verification is still valid. Determine if there is any verification that can be used before requesting verification from the person. Allow the household at least 10 days to provide missing information. The due date must fall on a workday.

E-2161.2.1 When a Renewal Form Is Not Returned

Revision 15-4; Effective October 1, 2015

When an acceptable FFCC renewal form is not returned, the system automatically makes an eligibility determination through a mass update based on the eligibility outcome from the automated renewal process. This does not require the CBS advisor to run eligibility or dispose the EDG.

Below are the eligibility outcomes during the automated process:

- Eligibility Potentially Approved – the client is auto-disposed and approved without advisor action. The file date is the date the EDG is auto-disposed approved, and the client is granted a new 12-month certification period.
- Additional Information Needed – the client is auto-disposed and denied without advisor action.

E-2161.2.2 Information or Renewal Form Returned After Termination

Revision 15-4; Effective October 1, 2015

When a renewal is denied due to failure to provide information or verification and the information or verification is provided after the date of denial but by the 90th day after the last day of the last benefit month, CBS staff must reopen the EDG. The date the information or verification is provided is the new file date.

If a renewal form is not received by the date of denial in the 12th month of the certification period, the EDG is denied for failure to return a renewal packet. A renewal form received after the last day of the 12-month certification period must be treated as an application using application processing time frames. The file date is the day that any local eligibility determination office receives the FFCC renewal form.

Note: If the renewal form is received after the date of denial but before the last day of the 12th month of the certification period, reopen the EDG and process as a renewal.

E-2170, Renewal Time Frames

Body

Revision 15-4; Effective October 1, 2015

For individuals required to return a renewal packet, CBS advisors must process the manual renewal following the time frames explained in E-2161.2, Processing a Manual Renewal.

E-2180, Pending Information

Body

Revision 15-4; Effective October 1, 2015

Advisors must allow the household at least 10 days to provide missing information/verification. The due date must be a workday. Advisors must request documents that are readily available to the household if the documents are anticipated to be sufficient verification. If the applicant has any active or inactive EDGs, check to see if any verification previously provided for the other EDGs can be used to determine eligibility for FFCC.

Advisors use verifications accepted for the Temporary Assistance for Needy Families (TANF) program, Medical Programs or the Supplemental Nutrition Assistance Program (SNAP).

Exception: Only Medical Programs sources of verification of U.S. citizenship for applicants can be used.

Note: Advisors must not use verification that is over 90 days old from the FFCC file date.

E—2181 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 15-4; Effective October 1, 2015

Case Action	Due Date	Final Due Date
Application	10 days	• 30th day, or • 10th day if the household's Form H1020 due date extends beyond the 30th day
Renewal	10 days	• 30th day or by cutoff in the last benefit month of certification, whichever is later; or • 10th day if the household's Form H1020 due date extends beyond the last day of the last benefit month
Incomplete review	10 days	10th day

Note: Staff have until the 45th day from the file date to determine eligibility for applications.

E-2200, Changes

E-2210, How to Report a Change

Body

Revision 15-4; Effective October 1, 2015

Customer Care Center (CCC) staff process all changes for Former Foster Care Children (FFCC) recipients. FFCC recipients can report changes:

- online through YourTexasBenefits.com;
- by visiting a local eligibility office;
- in writing by mail or fax;
- by completing Form H1019, Report of Change; or
- by calling 2-1-1.

Note: When a change is reported by telephone, staff must verify that the person speaking is the individual or an authorized representative as explained in A-2000, Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation.

An individual must report the following changes:

- if the individual moves out state,
- an address change, or
- enrollment in health insurance.

Advisors process all other changes, including agency-generated changes, at the next renewal.

Exception: If the individual failed to report required information at the time of the application that causes the individual to be ineligible for FFCC, advisors must deny the benefits and send a fraud referral to the Office of the Inspector General.

E-2220, Action on Changes

Body

Revision 20-4; Effective October 1, 2020

All changes or agency generated change tasks received during the 12-month continuous eligibility period should be documented and the change processed at renewal, except:

- death of the certified person;
- voluntary withdrawal;
- receipt of health insurance;
- moves out of Texas; or
- change of address.

If a change of address is received, mail the person form VR30, Texas Voter Registration Application. If the person contacts CBS or 2-1-1 to decline the opportunity to register to vote after receipt of form VR30, mail Form H1350, Opportunity to Register to Vote, to the person for a signature. File Form H1350 in the case record when the person returns the form and retain the form for at least 22 months.

Follow policy in B-532, Medicaid Reinstatement for Persons Released from Texas County Jails, if a person was incarcerated in a Texas County Jail and Medicaid is suspended.

Follow Medical Programs policy in B-600, Changes, for verification and documentation requirements.

Related Policy

Registering to Vote, A-1521
Medicaid Reinstatement for Persons Released from Texas County Jail, B-532
Changes, B-600

E-2221 Returned Mail

Revision 16-4; Effective October 1, 2016

When returned mail is received, the vendor creates and assigns a Returned Mail (RTML) task to Centralized Benefit Services (CBS) staff for processing.

Upon receipt of the RTML task, CBS staff must take the following actions:

1. Review the address on the returned mail, the case record, and the State Portal to determine whether the household has reported a new address. If a new address has been reported, process the address change and, if there is a Supplemental Nutrition Assistance Program (SNAP) Eligibility Determination Group (EDG), any related changes in shelter expenses.

2. If a new address has not been reported and a forwarding address was not provided, attempt to contact the household via telephone to obtain an updated address and document the attempt. If the household provides a new address, process the address change and, if there is a SNAP EDG, any related changes in shelter expenses. Otherwise go to Step 3.

3. If there is an individual(s) in the household who receives Retirement, Survivor's and Disability Insurance (RSDI) or Supplemental Security Income (SSI), use the State Online Query (SOLQ) to verify the household's address. Use the address in SOLQ to update the address if the address in SOLQ differs from the address on file and, if there is a SNAP EDG, explore shelter expenses.

If the address in SOLQ matches the address in the TIERS record, document in TIERS Case Comments that the SOLQ inquiry address matches the TIERS address and take no further action.

If unable to contact the individual by phone and there is not an individual(s) in the household who receives RSDI or SSI for the:

- FFCC EDG, go to Step 4; or
- SNAP EDG, follow Step 5 under the process for a case that includes a SNAP EDG in B-638 , Returned Mail.

4. If unable to update the address, simultaneously send emails using the following CBS email box to:

- Health Plan Operations (HPO) using the following email box:
  - cbs_ffche-mtfcy@hhsc.state.tx.us; and
- Preparation for Adult Living (PAL) using the following email box:
  - OES_FFCC@hhsc.state.tx.us

HPO Process

- Send an email to the Medicaid CHIP Division (MCD) Health Plan Operations (HPO) at HPO_Star_Plus@hhsc.state.tx.us.
- Include in the subject line **Returned Mail – [last four digits of the client's case number]**.
- Include the following information in the email:
- case name;
- case number;
- individual’s date of birth (DOB), Social Security Number (SSN), and Medicaid Individual Identification Number; and
- date the response is needed.
  - Leave the RTML task pending.

PAL Process

- Use the link below to identify the Lead Regional PAL staff covering the region of the client's last known address.
  - https://www.dfps.texas.gov/Child_Protection/Youth_and_Young_Adults/Preparation_For_Adult_Living/PAL_coordinators.asp
- Send an email to the identified Lead Regional PAL staff.
- Include in the subject line **Returned Mail -- [last four digits of the client's case number].**
- Include the following information in the email:
  - case name;
  - case number;
  - individual's DOB, SSN, and Medicaid Individual Identification Number; and
  - date the response is needed.
- Leave the RTML task Pending.

Note:

For an individual who aged out of the Unaccompanied Refugee Minor (URM) Resettlement program, contact the following agencies and individuals to determine if the agency or individual has an updated address for the former URM:

- the URM's former Voluntary Agency (VolAg); and
- the two agencies in Texas that have URM programs:
  - Catholic Charities Diocese of Fort Worth
    - Jennifer Frazier, URM Director, at jfrazier@ccdofw.org
  - Catholic Charities Diocese of Galveston-Houston
    - Debbie Sandberg, URM Coordinator, at 713-874-6505 or dsandberg@catholiccharities.org
    - Raj Kendrick, URM Director, at 281-874-6530 or rkendrick@catholiccharities.org

5. The MCD HPO and DFPS PAL staff have ten calendar days to respond. It is important that staff make the request as soon as possible. The response will include either:

- the known address on file for the individual; or
- no known address on file for the individual.

MCD HPO responds to the CBS email mailbox (cbs_ffche-mtfcy@hhsc.state.tx.us) and copies the original requestor with information from the plan by the tenth calendar day from when the email is sent, either confirming or denying that they have an address on file for the client. If they confirm, the response will include the address on file.

The **DFPS PAL** program responds to the email box (OES_FFCC@hhsc.state.tx.us) and copies the original requestor with information from the Lead Regional PAL staff by the tenth calendar day from when the email is sent, either confirming or denying that they have an address on file for the client. If they confirm, the response will include the address on file.

Note: If the MCD HPO and DFPS PAL both respond and provide different addresses, use the address received from the MCD HPO (unless the individual has already provided an address).

6. For cases with a SNAP EDG, if by the Form H1020 due date, the household:

- provides the requested information, process the address change for all active EDGs, including the FFCC EDG, and address any related changes in shelter expenses for the SNAP EDG; or
- fails to provide the requested information, deny the SNAP EDG for failure to provide information. Send Form TF0001, Notice of Case Action, using the denial reason, "Failed to Provide Information".

For the FFCC EDG, if by the 10th calendar day due date the HPO/PAL information:

- is provided, use the information to update the address in the TIERS record;
- is not provided, use the following steps to deny the EDG(s) using the denial reason "Unable to Locate" as stated in A-2344.1, Form TF0001 Required (Adequate Notice).
    - In Change Action Mode, go to "Household Information" and select "Yes" for the question "is the worker unable to locate the household?"
    - Run eligibility.

Note: The HPO/PAL information cannot be used to verify residence for SNAP EDGs.

7. If MCD HPO or DFPS PAL provide an updated address within 30 days of the EDG's denial due to "Unable to Locate," reopen the EDG.

For the SNAP EDG, if the household is denied for failure to provide information and provides a correct address within the advance notice adverse action period, reopen the EDG using the original certification period and process any related changes in shelter expenses. Please refer to the TIERS Advance Notice of Adverse Action Reference Guide in the ASK iT Knowledge Base for instructions.

Notes:

- If an address provided by MCD HPO or the DFPS PAL program differs from an address provided by the household, contact the household to resolve the discrepancy.
- For SNAP EDGs, if the household provides verification of residence, but does not provide information regarding shelter expenses, re-budget eligibility without the shelter expense and notify the household, according to policy in A-631, Actions on Changes.

Related Policy

Actions on Changes, B-631
Returned Mail, B-638

E-2300 Fair Hearings

E-2310, Appeals Procedures

Body

Revision 15-4; Effective October 1, 2015

Individuals on Medicaid for Former Foster Care Children (FFCC) have the right to appeal within 90 days from the effective date of any Texas Health and Human Services Commission (HHSC) action. The individual's request may be oral or in writing.
See B-1000, Fair Hearings, for specific appeals policy and procedures.

E-2400, Automated Support

E-2410, Electronic Data Sources and Data Broker

Body

Revision 15-4; Effective October 1, 2015

Advisors must follow the policy explained in C-817, Electronic Data Sources (ELDS), and C-820, Data Broker.

Exception: The consent policy explained in C-817 does not apply to individuals who are transferred to the Texas Health and Human Services Commission (HHSC) via the Texas Department of Family and Protective Services (DFPS) interface.

Part F, Former Foster Care in Higher Education

F-100, Application Processing

F-110, Application Procedures

Body

Revision 20-2; Effective April 1, 2020

The Former Foster Care in Higher Education (FFCHE) program provides medical coverage to certain former foster care youth enrolled in an institution of higher education located in Texas. FFCHE is funded entirely by the state and is not considered Medicaid. It is identified as a Health Care Benefits program instead of Medicaid or medical assistance.

People living in Texas who age out of foster care under an Interstate Compact on the Placement of Children (ICPC) agreement may be eligible for FFCHE or Medicaid for Transitioning Foster Care Youth (MTFCY), explained in Part M, Medicaid for Transitioning Foster Care Youth (MTFCY). Automatically recertify current FFCHE recipients who are up for eligibility redetermination.

A person who ages out of foster care under an ICPC agreement may apply for FFCHE by completing Form H1205, Texas Streamlined Application, or Form H1205-S and submitting the form:

- online through YourTexasBenefits.com(link is external);
- by mail to the HHSC Document Processing Center (DPC) at:

  HHSC
  P.O. Box 149024
  Austin, TX 78714-9024;

or

- by toll-free fax to 877-447-2839.

Applicants may request to apply for FFCHE as explained in A-113, Application Requests and Submissions.

When a request for Form H1205 is received, Centralized Benefit Services (CBS) staff determine if the applicant needs the English or Spanish version of the form.

Note: CBS staff accept any of the applications explained in A-113, Application Requests and Submissions, and request any additional information needed to make an eligibility determination.

If a local eligibility determination office receives an application, staff must date stamp and fax the application to the DPC non-expedited fax line (877-447-2839) no later than the next business day.

Note: Policy found in A-121, Receipt of Application, outlines what constitutes a valid application and what process to follow when the agency receives an incomplete application.

Related Policy

Receipt of Application, A-121
Registering to Vote, A-1521

F—111 Type of Assistance (TA) 77 – Health Care – FFCHE

Revision 19-4; Effective October 1, 2019

To be eligible for FFCHE benefits, a person must:

- have had an ICPC agreement*;
- currently reside in Texas;
- be ages 21 up to 23;

- have been in any state's conservatorship on their 18th birthday;
- be enrolled in an institution of higher education located in Texas;
- not have adequate health coverage as defined by HHSC; and
- meet all other medical programs eligibility criteria such as citizenship or alien eligibility.

*Staff must contact the Texas Department of Family and Protective Services (DFPS) to determine whether the person had an ICPC agreement. DFPS has three business days to respond.

Specialized staff process all FFCHE case actions.

F—112 Reserved for Future Use

Revision 20-2; Effective April 1, 2020

F—113 Reserved for Future Use

Revision 20-2; Effective April 1, 2020

F—114 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

An individual may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

F-120, Office Procedures

Body

F—121 Reserved for Future Use

Revision 20-2; Effective April 1, 2020

F—122 File Date

Revision 15-4; Effective October 1, 2015

The file date is the day any local eligibility determination office, call center vendor, or other HHSC-contracted entity accepts an application containing the applicant's name, address and an appropriate signature. The file date is considered day zero in the application process.

Advisors must document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on the application, or
- the application has two received dates (stamp dates).

Note: For applications received outside of normal business hours, the file date is the next business day.

F-130, Interviews

Body

F—131 General Policy

Revision 15-4; Effective October 1, 2015

An interview is not required when applying for or renewing an application for the FFCHE program. Advisors must schedule a phone interview only if the individual requests an interview. The State Portal Scheduler does not support scheduling an interview for the FFCHE program. Any requests for an interview must be scheduled manually.

Note: An application must not be denied if the applicant misses the interview, and the advisor should continue to determine eligibility.

F-200, Household Composition

F-210, General Policy

Body

Revision 15-4; Effective October 1, 2015

The Modified Adjusted Gross Income (MAGI) household composition and certified Eligibility Determination Group (EDG) for Former Foster Care in Higher Education (FFCHE) consists of the applicant only. The applicant is the only certified member on the FFCHE EDG.

Example: An individual, age 22, is married and lives with her husband and their child. The individual applies for and is eligible for the FFCHE program. The MAGI household composition and certified EDG consists of only the individual. Her husband and child are not included.

F-220, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

There are no verification requirements for household composition. Accept the individual's statement as verification.

F-300, Citizenship

F-310, General Policy

Body

Revision 15-4; Effective October 1, 2015

The Former Foster Care in Higher Education (FFCHE) program follows the Medical Programs policy for citizenship and alien status eligibility in A-300, Citizenship.

Exception: Applicants do not receive the period of reasonable opportunity explained in A-351.1, Reasonable Opportunity.

Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for FFCHE if they meet all other eligibility criteria.

Reminder: The State Online Query (SOLQ) and the Wire Third-Party Query (WTPY) inquiry systems cannot be used to verify citizenship for this program. See F-2140, Pending Information on Applications.

F-400, Social Security Number

F-410, General Policy

Body

Revision 20-2; Effective April 1, 2020

All applicants must provide a Social Security number (SSN) or apply for one through the Social Security Administration before certification. The Former Foster Care in Higher Education (FFCHE) program follows the SSN policy in A-400, Social Security Number, under the All Programs or Medical Programs headings.

F-500, Age

F-510, General Policy

Body

Revision 15-4; Effective October 1, 2015

Applicants are eligible to receive Former Foster Care in Higher Education (FFCHE) program benefits beginning the month after their 21st birthday through the end of the month of their 23rd birthday. Applicants who wish to have coverage during the month of their 21st birthday must apply for benefits under an appropriate Medicaid program.

Note: These individuals may be eligible for Medicaid for Transitioning Foster Care Youth (MTFCY) during the month of their 21st birthday. See Part M, Medicaid for Transitioning Foster Care Youth (MTFCY).

F-520, Verification Requirements

Body

Revision 10-2; Effective April 1, 2010

Accept self-declaration as verification of age.

F-530, Documentation Requirements

Body

Revision 10-2; Effective April 1, 2010

Document the individual's self-declaration establishing the age.

F-600, Relationship

Body

Revision 15-4; Effective October 1, 2015

Relationship requirements do not apply to the Former Foster Care in Higher Education (FFCHE) program.

F-700, Identity

F-710, General Policy

Body

Revision 10-2; Effective April 1, 2010

To establish identity, follow the Medical Programs policy in A-600, Identity.

F-800, Residence

F-810, General Policy

Body

Revision 15-4; Effective October 1, 2015

To determine residence eligibility, follow TP 33, TP 34, TP 35, TP 43, TP 44, TP 45 and TP 48 policy in A-700, Residence.

F-900, Adequate Health Coverage (Third-Party Resource)

F-910, General Policy

Body

Revision 17-2; Effective April 1, 2017

An applicant/recipient is not eligible to receive Former Foster Care in Higher Education (FFCHE) benefits if the individual currently has adequate health coverage. Adequate health coverage is also known as a third-party resource (TPR). Adequate health coverage is defined as receiving coverage under:

- group health insurance;
- health insurance coverage;
- Medicare (Part A or Part B);
- Medicaid (with the exception of the Healthy Texas Women, Medicaid with Spend Down, and Community Attendant);
- armed forces insurance; or
- a state health risk pool.

Deny an application for an individual who has adequate health coverage.

Do not consider a plan with a limited scope of coverage such as dental, vision, long-term care, etc., or for only a specific illness/disease, such as drug/substance abuse, as adequate health coverage.

Consider an applicant/recipient as having adequate health coverage even if it has limits on benefits or high deductibles.

If staff receive a task with information that the individual has TPR and the "NHIC" box is greyed out, advisors deny rather than pend the EDG. This information has already been verified by the Office of Inspector General – Third Party Liability area.

When an FFCHE applicant is denied due to adequate health care coverage, Form TF0001, Notice of Case Action, will read:

"We found that you already have private health insurance. To learn more about the insurance you already get, call toll-free 1-800-846-7307 (after you pick a language, press 2)."

In some instances, the parents of FFCHE recipients have TPR coverage for them without the individual knowing. If the individual states they are not aware of the TPR, staff should advise them to call the claims administrator's Third Party Liability Customer Service Line at 1-800-846-7307 and select option 2. This will allow the individual to obtain information regarding their TPR.

If the TPR information in the Texas Integrated Eligibility Redesign System (TIERS) has been verified by the claims administrator but needs to be updated, staff should fax the completed Form H1039, Medical Insurance Input, to the claims administrator at 512-514-4215.

F-920, Verification Requirements

Body

Revision 10-2; Effective April 1, 2010

Accept self-declaration of adequate health coverage.

Exception: If an applicant is denied due to receiving adequate health coverage and the applicant calls to notify HHSC that the medical insurance is not adequate health coverage, staff would need to verify if the coverage is considered adequate health coverage.

F-930, Documentation Requirements

Body

Revision 10-2; Effective April 1, 2010

Staff must document in case comments the existence of adequate health coverage.

F-1000, Eligibility Begin Dates

F-1010, General Policy

Body

Revision 15-4; Effective October 1, 2015

The applicant is eligible for 12 months beginning the first day of the application month if all eligibility criteria are met. The applicants are eligible to receive benefits beginning the month after their 21st birthday through the end of the month of their 23rd birthday.

The medical effective date cannot precede the:

- effective date of the program (October 1, 2009), or
- the month after the individual's 21st birthday.

If an applicant applies in the month of the applicant's 21st birthday, the individual cannot be eligible for the Former Foster Care in Higher Education (FFCHE) program until the following month.

Applicants who wish to have coverage during the month of their 21st birthday must apply for benefits under an appropriate Medicaid program.

Note: These individuals may be eligible for Medicaid for Transitioning Foster Care Youth (MTFCY) during the month of their 21st birthday. See Part M, Medicaid for Transitioning Foster Care Youth (MTFCY).

Examples:

- An individual turns age 21 on May 5. She filed an FFCHE application on May 1. The individual is ineligible to receive FFCHE during May, the month of application, since she turns 21 during May. Her eligibility begin date will be June 1. If the applicant wishes to receive benefits for the application month, she must file an application for an appropriate Medicaid program.
- The individual turns age 23 on May 5. She is no longer eligible to receive FFCHE benefits effective June 1.

Three months prior coverage is not available in the FFCHE program. An applicant may apply for three months prior coverage under a Medicaid program and receive assistance if eligible.

In the event an FFCHE recipient becomes pregnant and does not apply for or is not eligible for Medicaid, the newborn is not eligible for TP 45 – Medicaid for Newborn Children. If the mother wants coverage for the baby, she must apply for Medicaid; if eligible, the child will be certified for TP 43 – Medical Assistance for Children Under Age 1.

F—1011 Types of Coverage

Revision 15-4; Effective October 1, 2015

FFCHE recipients will have two types of coverage. The type of coverage determines how recipients access their health care services.

Fee-for-Service – Initial coverage for FFCHE recipients. Although FFCHE individuals are not Medicaid recipients, they will have access to any Medicaid provider and will be allowed to self-refer to specialists. The provider submits claims directly to the claims administrator for reimbursement of the FFCHE-covered services (the coverage mirrors services available to Medicaid recipients). The Texas Health and Human Services Commission (HHSC) will use state funds to pay these claims.

Managed Care – A service delivery program that provides medical care in a managed care setting. The state pays a monthly premium to the health maintenance organization (HMO) for each recipient enrolled in the plan. The plan processes all provider claims.

Enrollment into managed care is mandatory for FFCHE recipients; however, when a recipient is determined eligible for the FFCHE program, fee-for-service coverage is provided until the recipient is enrolled into managed care. Managed care coverage is determined using prospective enrollment following current cutoff rules. Managed care health benefits are provided through the STAR Program.

Example: An application is received on January 1 and processed on January 25 (after cutoff); the managed care effective date is March 1. The initial months (January and February) will be covered as fee-for-service.

F-1100, Domicile

Body

Revision 10-2; Effective April 1, 2010

Domicile requirements do not apply to the Former Foster Care in Higher Education program.

F-1200, Deprivation

Body

Revision 10-2; Effective April 1, 2010

Deprivation requirements do not apply to the Former Foster Care in Higher Education program.

F-1300, Child Support

Body

Revision 10-2; Effective April 1, 2010

Child and medical support requirements do not apply to the Former Foster Care in Higher Education program.

F-1400, Resources

Body

Revision 15-4; Effective October 1, 2015

Resources are not considered in determining eligibility for Former Foster Care in Higher Education (FFCHE).

F-1500, Income

Body

Revision 15-4; Effective October 1, 2015

Income is not considered as a factor in determining eligibility for Former Foster Care in Higher Education (FFCHE).

F-1600, Deductions

Body

Revision 15-4; Effective October 1, 2015

Since there is no income test, deductions are not considered as a factor in determining eligibility for Former Foster Care in Higher Education (FFCHE).

F-1700, School Enrollment

F-1710, General Policy

Body

Revision 15-4; Effective October 1, 2015

An applicant or recipient must be enrolled in an institution of higher education located in Texas to receive Former Foster Care in Higher Education (FFCHE) health care benefits. The applicant/recipient may be attending school half-time or full-time. There is no requirement regarding the number of hours the student must be taking. The following are considered institutions of higher education:

- college (public or private),
- community college,
- junior college,
- technical institute, and
- university.

Note: Trade schools such as beauty schools or mechanic schools do not meet the definition of an institution of higher education.

F-1720, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

School enrollment must be verified at application and renewal. The following are valid sources of verification for school enrollment:

- financial aid statement;
- enrollment certification;
- official fee receipt; and
- Form H1870, School Enrollment Verification Form.

Note: Online courses are only acceptable if the university/college has a branch located in Texas.

F-1730, Documentation Requirements

Body

Revision 10-2; Effective April 1, 2010

Document the type of institution the applicant/recipient is attending and the source of school enrollment verification.

F-1800, Management

Body

Revision 15-4; Effective October 1, 2015

Management requirements are not applicable for the Former Foster Care in Higher Education (FFCHE) program.

F-1900, Reminders

F-1910, General Policy

Body

Revision 15-4; Effective October 1, 2015

Before certifying applicants and recertifying recipients, complete the following:

- Ensure the applicant completes each question and signs and dates the application.
- Give the applicant Form H1019-F, Reporting Changes to Your Case. Explain that changes must be reported within 10 days after knowing about the change. Indicate the appropriate reporting requirement on Page 1.
- Refer the applicant to other programs for which the individual might be eligible such as the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Medicaid; Supplemental Security Income (SSI); or Retirement, Survivors and Disability Insurance (RSDI). Refer individuals with a disability who are ineligible for Medical Programs for families and children to the Texas Health and Human Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) programs.
- Inform applicants of the right to request a review of their case for any HHSC action that affects their eligibility.
- Inform the applicant that the information provided is subject to verification by third parties.

There is no requirement to inform individuals to report accidents.

F-1920, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

Document that form VR30, Texas Voter Registration Application, was given to the applicant, authorized representative or representative payee in the Agency Use Only section of the application.

Related Policy

Registering to Vote, A-1521

F-2000, Case Disposition

Body

F—2010 Notice to Applicants

Revision 15-4; Effective October 1, 2015

When processing an application, redetermination or change, advisors are required to inform the individual if their request is pended, certified, sustained, or denied. Eligibility Determination Group (EDG) disposition is the end result of processing the request for assistance and will generate Form TF0001, Notice of Case Action. However, if the EDG cannot be disposed because it is pending for additional information/verification, the advisor must provide the individual with Form H1020, Request for Information or Action.

Form H1020, Request for Information or Action

Form H1020 informs the individual of the:

- reason the case is pending;
- action the individual or advisor must take;
- date by which the individual or advisor must take action; and
- date the advisor must deny the application or case if the individual does not take action, if applicable.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

Form TF0001F, Notice of Case Action

TF0001F informs the individual:

- the date benefits begin; or
- the date of denial; and
- about his/her right to request a review of the case action.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

F—2020 Length of Certification

Revision 15-4; Effective October 1, 2015

The Texas Integrated Eligibility Redesign System (TIERS) calculates the eligibility end date from the date the advisor disposes the EDG as follows:

- Applications – initial certification month plus 11 months.
- Renewals – 12 months from the last certification month.

Individuals are eligible for Former Foster Care in Higher Education (FFCHE) health care benefits for 12 months or through the month of their 23rd birthday, whichever is earlier.

Exception: A individual is not eligible to receive 12 months of coverage if the individual:

- reaches age 23,
- dies,
- voluntarily withdraws,
- moves out-of-state,
- reports receipt of adequate health coverage, or
- is not attending an institution of higher education.

F—2030 Setting Special Reviews

Revision 15-4; Effective October 1, 2015

Use Medical Programs policy in A-2330, Setting Special Reviews, to set special reviews.

F—2040 Adverse Action

Revision 15-4; Effective October 1, 2015

After certification, give households advance notice of adverse actions to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

Former FFCHE recipients receiving a notice of adverse action do not have the right to request a fair hearing. FFCHE recipients can request a review of their case action. See F-2300, Request for Review.

F-2100, Processing Time Frames

F-2110, Applications

Body

Revision 15-4; Effective October 1, 2015

Advisors must make an eligibility determination by the 45th day from the file date.

Reopen an application denied for failing to furnish information/verification if the missing information is provided by the 60th day from the file date. Use the date the missing information/verification was provided as the new file date.

Use the original application or renewal form until it is 60 days old. If the information on the form has changed or is more than 45 days old, the individual and advisor must update the form.

F-2120, Deadlines

Body

Revision 10-2; Effective April 1, 2010

Provide Form TF0001-F, Notice of Case Action, the same day eligibility is determined for an application but no later than 45 days from the file date.

F-2130, Missed Interviews

Body

Revision 10-2; Effective April 1, 2010

No interview is required to process an application or renewal unless requested by the applicant or recipient. If requested, provide the individual with a telephone interview. If the individual fails to keep the interview, do not deny the application or renewal but continue to process the request for assistance.

F-2140, Pending Information on Applications

Body

Revision 10-2; Effective April 1, 2010

Advisors must request documents that are readily available to the household and consider it sufficient verification. Use the verification sources listed in the various eligibility elements of Part A, Determining Eligibility, as potential and acceptable sources of verification. C-900, Verification and Documentation, gives information on verification procedures.

In determining eligibility, staff must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

F-2150, Notice of Renewal/Expiration

Body

Revision 15-4; Effective October 1, 2015

The Texas Integrated Eligibility Redesign System (TIERS) sends a renewal packet containing Form H1869, Renewal for Health Care Services; Form H1870, School Enrollment Verification Form; and a business reply envelope in the 11th month of the 12-month certification period.

F-2160, Processing Renewals

Body

F—2161 How to Process a Renewal

Revision 15-4; Effective October 1, 2015

Former Foster Care in Higher Education (FFCHE) recipients receive a passive renewal. Individuals are only required to return a renewal packet if information they provided during the application process has changed. If the individual does not return a renewal packet by the first calendar day of the last month of the certification period, TIERS automatically re-certifies the FFCHE Eligibility Determination Group (EDG) for another 12-month period, or through the month of the individual's 23rd birthday, whichever is earlier. This will not require the Centralized Benefit Services (CBS) advisor to run eligibility or dispose the case.

Exception: School enrollment must be verified at application or renewal for FFCHE. If an FFCHE individual does not return the renewal packet, TIERS will process the passive renewal and will pend the EDG for school enrollment verification. If verification is not provided, the advisor will be required to run eligibility and dispose the case to sustain or deny benefits.

There is no interview requirement for an FFCHE renewal. The file date is the day any local Texas Health and Human Services Commission (HHSC) eligibility determination office receives the FFCHE application.

Verification from an associated EDG can be used if provided within 90 days of the FFCHE file date.

Follow the policy below when Form H1869/Form H1869-S, Renewal for Health Care Benefits, is returned for a renewal.

If the individual provides Form H1869/Form H1869-S indicating no change and has an associated EDG, review the associated EDG to determine if there is any conflicting data and if there is any documentation to clear the conflicting information. If not, request new verification via Form H1020, Request for Information or Action.

If the individual returns Form H1869/Form H1869-S reporting changes, provides verification and there are no associated EDGs, process the renewal using the new verification.

If the individual returns Form H1869/Form H1869-S reporting changes, provides verification and there are associated EDGs, review the associated EDGs and use the most recent information provided.

If the associated EDGs have other information the family did not report for the FFCHE EDG that would impact FFCHE eligibility, contact the individual (by telephone or Form H1020 with due date) to determine if the information in the associated EDGs is correct before denying or taking adverse action on the EDG.

If the individual returns Form H1869/Form H1869-S reporting changes without verification and has associated EDGs, request new verification via Form H1020.

If the individual returns Form H1869/Form H1869-S indicating changes, does not provide verification and does not have associated EDGs, request information needed to determine eligibility. If the individual does not provide the information, do not renew eligibility.

F-2170, Renewal Time Frames

Body

Revision 10-2; Effective April 1, 2010

If the individual returns a renewal packet, advisors must make an eligibility determination by the 30th day from the file date.

Note: A renewal application is considered a renewal if it is received by the last day of the 12-month certification period.

Reopen a renewal application denied for failing to furnish information or verification if the missing information/verification is provided by the 60th day from the file date. Use the date the missing information/verification was provided as the new file date.

Use the original Form H1869/Form H1869-S, Renewal for Health Care Benefits, until it is 60 days old. If the information on Form H1869/Form H1869-S has changed or is more than 45 days old, the individual and advisor must update the form.

Reminder: Consider a renewal application received after the last day of the 12-month certification period as an application using application processing time frames.

F-2180, Pending Information

Body

Revision 15-4; Effective October 1, 2015

Allow the household at least 10 days to provide missing information/verification. The due date must be a workday. Advisors must request documents that are readily available to the household if the documents are anticipated to be sufficient verification. If the applicant has any active or inactive EDGs, check to see if any verification previously provided for another EDG can be used to determine eligibility for FFCHE.

Use verifications accepted for Temporary Assistance for Needy Families (TANF), Medical Programs or the Supplemental Nutrition Assistance Program (SNAP).

For example, if you accept wage verification for a SNAP case, that same verification is acceptable for TANF, Medical Programs or FFCHE.

Exception: Verification of U.S. citizenship for applicants must be from a Medicaid-acceptable source. Staff cannot access the State Online Query/Wire Third-Party Query (SOLQ/WTPY) inquiry to verify citizenship or Retirement, Survivors and Disability Insurance (RSDI) for FFCHE processing. Advisors must request other types of verification, such as copies of birth certificates for citizenship and award letters for RSDI benefits.

Note: Do not use verification that is over 90 days old from the FFCHE file date.

F—2181 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 15-4; Effective October 1, 2015

Case Action	Due Date	Final Due Date
Application	10 days	• 30th day, or • 10th day if the household's Form H1020 due date extends beyond the 30th day
Renewal	10 days	30th day, or by the 10th day if the household's Form H1020 due date extends beyond the last day of the last benefit month
Incomplete review	10 days	10th day

Note: Staff have until the 45th day from the file date to determine eligibility for applications.

F-2200, Changes

F-2210, How to Report a Change

Body

Revision 15-4; Effective October 1, 2015

Centralized Benefit Services (CBS) staff process all changes for Former Foster Care in Higher Education (FFCHE) recipients. FFCHE recipients can report changes:

- online through YourTexasBenefits.com;
- by visiting a local eligibility determination office (which will forward the change to CBS);
- by calling 2-1-1; or
- in writing, by mail or fax, or by completing Form H1019-F, Reporting Changes to Your Case. The individual may mail or fax the change to:
  - Document Processing Center:
    HHSC
    P.O. Box 149024
    Austin, TX 78714-9024
    Toll-free fax: 1-877-447-2839
  - A local eligibility determination office (which must send the change to CBS).

Note: When an FFCHE recipient reports a change by telephone, staff must verify that the person speaking is the individual or the authorized representative.

An FFCHE recipient must report the following changes:

- Address changes
- Receipt of health insurance
- Pregnancy

- If the individual moves out of state
- School enrollment status – no longer attending school

Exception: Individuals receiving FFCHE as of December 2013 and not eligible for Former Foster Care Children (FFCC) must also report income changes.

F-2220, Action on Changes

Body

Revision 10-2; Effective April 1, 2010

Follow policy listed in B-600, Changes, for Medical Programs to determine how to process changes for FFCHE recipients.

F-2300, Request for Review

F-2310, Request for Review Procedures

Body

Revision 20-4; Effective October 1, 2020

FFCHE recipients receiving notice of adverse action are not entitled to continued benefits when benefits are denied for any reason and granting continued benefits would extend the 12-month eligibility period or extend the benefits past the person's 23rd birthday.

FFCHE recipients do not have the right to request a fair hearing. FFCHE recipients can request a review of the case action. A request for review is any expression of dissatisfaction with an adverse action. Inform FFCHE recipients that requests for review must be submitted in writing.

FFCHE recipients have 30 business days from the date of the notification letter to submit a request for review concerning the decision that resulted in an adverse action. They must submit the request for review in writing to:

- Texas Health and Human Services Commission
  Attention: Complaint Department
  P. O. Box 149027
  Austin, TX 78714-9027; or
- by toll-free fax to 877-542-5951.

Upon receipt of the request for review, CBS staff review the adverse action and respond in writing within 10 business days from the date of receipt of the request. The response letter (Form TF0001F, Notice of Case Action) has information about the agency's answer to the request for review. Document the final decision in TIERS Case Comments.

When a request for review is received after 30 business days or the request for review is not for an adverse action, deny the request and generate Form TF0001F, to inform the household of the denial reason.

F-2400, Automated Support

F-2410, Data Broker

Body

Revision 15-4; Effective October 1, 2015

Advisors must follow the policy explained in C-817, Electronic Data Sources (ELDS), and C-820, Data Broker.

Part M, Medicaid for Transitioning Foster Care Youth

M-100, Application Processing

Body

Revision 15-4; Effective October 1, 2015

The Chafee Foster Care Independence Act of 1999 gave states the option to extend Medicaid coverage to the population of youth who are between ages 18 and 21 and have aged out of foster care. Senate Bill 51, 77th Texas Legislature, Regular Session, 2001, was passed and signed into law effective September 1, 2001. This law allows the state to provide Medicaid coverage to youths who are aging out of foster care until they reach their 21st birthday.

The process to cover these individuals is coordinated between the Texas Department of Family and Protective Services (DFPS), which administers the foster care program, and the Texas Health and Human Services Commission (HHSC). When a child who is not eligible for Former Foster Care Children (FFCC) ages out of foster care in Texas, Medicaid eligibility is transferred from Foster Care Medicaid to Medicaid for Transitioning Foster Care Youth (MTFCY). DFPS certifies initial MTFCY eligibility for youths aging out of foster care and HHSC is then responsible for determining their future Medicaid eligibility.

Note: There may be situations in which HHSC processes the initial certification.

M—111 Type of Assistance (TP) 70 – Medical Assistance – MTFCY

Revision 19-4; Effective October 1, 2019

To be eligible for MTFCY, a person must:

- be ineligible for FFCC (see Part E, Former Foster Care Children [FFCC]);
- be ages 18 up to 21;
- have been in foster care in Texas on their 18th birthday, or have had an Interstate Compact on the Placement of Children (ICPC) agreement*;
- meet medical programs citizenship and Social Security number requirements;
- be a Texas resident;
- not have adequate health coverage as defined by HHSC; and
- have countable income equal to or less than the applicable income limit for TP 70, defined in C-131.1, Federal Poverty Income Limits (FPIL). **Exception:** Persons who have had an ICPC agreement do not need to meet the income requirement.

* Centralized Benefit Services (CBS) staff must contact DFPS to determine whether the person had an ICPC agreement. DFPS has three business days to respond.

Specialized staff process all MTFCY case actions.

M—112 Application Processing

Revision 20-3; Effective July 1, 2020

Centralized Benefit Services (CBS) staff receive:

- a new MTFCY case/Eligibility Determination Group (EDG) via an interface with the Texas Department of Family and Protective Services (DFPS); or
- an application completed by a person who aged out of foster care.

Note: DFPS provides a notice of eligibility to each person.

CBS staff are notified by DFPS or HHSC Quality Assurance when a referral or interface is not completed. If a DFPS referral or interface is not completed or processed, CBS staff must contact DFPS to determine the reason the person was not sent to HHSC via the interface and confirm whether eligibility criteria are met for MTFCY. If the person meets the eligibility criteria in M-111, Type of Assistance (TP) 70 - Medical Assistance - MTFCY, CBS staff certify the person for MTFCY without requiring an application.

There are instances when a person is denied ongoing MTFCY coverage and must submit a new application for benefits. A person may be denied ongoing MTFCY coverage if they:

- voluntarily withdraw;
- move out of state; or
- fail to return verification during a renewal.

A person denied ongoing MTFCY benefits may experience a gap in coverage. When there is a gap in coverage, the person must apply using any of the Medical Programs application channels explained in A-113, Application Requests and Submissions.

The question "Were you in foster care at age 18 or older?" must be marked **Yes** on the application for eligibility to be considered for MTFCY.

If ineligible for MTFCY, the person will be considered for eligibility under other Medical Programs.

M—113 Requesting an Application

Revision 15-4; Effective October 1, 2015

Applicants may request to apply for MTFCY as explained in A-113, Application Requests and Submissions.

If an applicant requests help completing an application, a volunteer or staff member must provide assistance. Anyone assisting the applicant in completing a paper application must initial the part completed, or sign the form indicating assistance was provided.

Related Policy

Registering to Vote, A-1521

M—114 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

An individual may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

M—120 Office Procedures

Revision 10-2; Effective April 1, 2010

M—121 Filing an Application

Revision 17-1; Effective January 1, 2017

Individuals who wish to apply for MTFCY can:

- submit an application as explained in A-113, Application Requests and Submissions; and
- sign an application as explained in A-122, Application Signature.

M—122 File Date

Revision 20-4; Effective October 1, 2020

The file date is the day an application is received in one of the following ways:

- by an HHSC eligibility determination office;
- online through YourTexasBenefits.com;
- by phone through 2-1-1; or
- through an account transfer from the Marketplace.

The file date is the day any HHSC eligibility determination office or call center vendor accepts an application containing the applicant's name, address, and appropriate signature. This is day zero in the application process.

Document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on the application; or
- the application has two received dates (stamp dates).

Note: For applications received outside of normal business hours, the file date is the next business day.

Related Policy

Application Signature, A-122.1

M—130 Interviews

Revision 10-2; Effective April 1, 2010

M—131 General Policy

Revision 10-2; Effective April 1, 2010

An interview is not required when applying for or renewing an application for the MTFCY program. Schedule a phone interview only if the individual requests an interview. The State Portal Scheduler does not support scheduling of the MTFCY program. Any requests for an

interview must be scheduled manually.

Note: Do not deny the application if the applicant misses the interview; continue determining eligibility.

M-110, Medicaid for Transitioning Foster Care Youth

Body

Revision 20-4; Effective October 1, 2020

M—110 Medicaid for Transitioning Foster Care Youth (MTFCY)

Revision 15-4; Effective October 1, 2015

The Chafee Foster Care Independence Act of 1999 gave states the option to extend Medicaid coverage to the population of youth who are between ages 18 and 21 and have aged out of foster care. Senate Bill 51, 77th Texas Legislature, Regular Session, 2001, was passed and signed into law effective September 1, 2001. This law allows the state to provide Medicaid coverage to youths who are aging out of foster care until they reach their 21st birthday.

The process to cover these individuals is coordinated between the Texas Department of Family and Protective Services (DFPS), which administers the foster care program, and the Texas Health and Human Services Commission (HHSC). When a child who is not eligible for Former Foster Care Children (FFCC) ages out of foster care in Texas, Medicaid eligibility is transferred from Foster Care Medicaid to Medicaid for Transitioning Foster Care Youth (MTFCY). DFPS certifies initial MTFCY eligibility for youths aging out of foster care and HHSC is then responsible for determining their future Medicaid eligibility.

Note: There may be situations in which HHSC processes the initial certification.

M—111 Type of Assistance (TP) 70 – Medical Assistance – MTFCY

Revision 19-4; Effective October 1, 2019

To be eligible for MTFCY, a person must:

- be ineligible for FFCC (see Part E, Former Foster Care Children [FFCC]);
- be ages 18 up to 21;
- have been in foster care in Texas on their 18th birthday, or have had an Interstate Compact on the Placement of Children (ICPC) agreement*;
- meet medical programs citizenship and Social Security number requirements;
- be a Texas resident;
- not have adequate health coverage as defined by HHSC; and
- have countable income equal to or less than the applicable income limit for TP 70, defined in C-131.1, Federal Poverty Income Limits (FPIL). **Exception:** Persons who have had an ICPC agreement do not need to meet the income requirement.

* Centralized Benefit Services (CBS) staff must contact DFPS to determine whether the person had an ICPC agreement. DFPS has three business days to respond.

Specialized staff process all MTFCY case actions.

M—112 Application Processing

Revision 20-3; Effective July 1, 2020

Centralized Benefit Services (CBS) staff receive:

- a new MTFCY case/Eligibility Determination Group (EDG) via an interface with the Texas Department of Family and Protective Services (DFPS); or
- an application completed by a person who aged out of foster care.

Note: DFPS provides a notice of eligibility to each person.

CBS staff are notified by DFPS or HHSC Quality Assurance when a referral or interface is not completed. If a DFPS referral or interface is not completed or processed, CBS staff must contact DFPS to determine the reason the person was not sent to HHSC via the interface and confirm whether eligibility criteria are met for MTFCY. If the person meets the eligibility criteria in M-111, Type of Assistance (TP) 70 - Medical Assistance - MTFCY, CBS staff certify the person for MTFCY without requiring an application.

There are instances when a person is denied ongoing MTFCY coverage and must submit a new application for benefits. A person may be denied ongoing MTFCY coverage if they:

- voluntarily withdraw;
- move out of state; or
- fail to return verification during a renewal.

A person denied ongoing MTFCY benefits may experience a gap in coverage. When there is a gap in coverage, the person must apply using any of the Medical Programs application channels explained in A-113, Application Requests and Submissions.

The question "Were you in foster care at age 18 or older?" must be marked **Yes** on the application for eligibility to be considered for MTFCY.

If ineligible for MTFCY, the person will be considered for eligibility under other Medical Programs.

M—113 Requesting an Application

Revision 15-4; Effective October 1, 2015

Applicants may request to apply for MTFCY as explained in A-113, Application Requests and Submissions.

If an applicant requests help completing an application, a volunteer or staff member must provide assistance. Anyone assisting the applicant in completing a paper application must initial the part completed, or sign the form indicating assistance was provided.

Related Policy
Registering to Vote, A-1521

M—114 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

An individual may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

M-120, Office Procedures

Body

M-121 Filing an Application

Revision 17-1; Effective January 1, 2017

Individuals who wish to apply for MTFCY can:

- submit an application as explained in A-113, Application Requests and Submissions; and
- sign an application as explained in A-122, Application Signature.

M-122 File Date

Revision 20-4; Effective October 1, 2020

The file date is the day an application is received in one of the following ways:

- by an HHSC eligibility determination office;
- online through YourTexasBenefits.com;
- by phone through 2-1-1; or
- through an account transfer from the Marketplace.

The file date is the day any HHSC eligibility determination office or call center vendor accepts an application containing the applicant's name, address, and appropriate signature. This is day zero in the application process.

Document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on the application; or
- the application has two received dates (stamp dates).

Note: For applications received outside of normal business hours, the file date is the next business day.

Related Policy

Application Signature, A-122.1

M-130, Interviews

Body

M—131 General Policy

Revision 10-2; Effective April 1, 2010

An interview is not required when applying for or renewing an application for the MTFCY program. Schedule a phone interview only if the individual requests an interview. The State Portal Scheduler does not support scheduling of the MTFCY program. Any requests for an interview must be scheduled manually.

Note: Do not deny the application if the applicant misses the interview; continue determining eligibility.

M-200, Household Composition

M-210, General Policy

Body

Revision 15-4; Effective October 1, 2015

To determine the Modified Adjusted Gross Income (MAGI) household composition for Medicaid for Transitioning Foster Care Youth (MTFCY), the advisor follows the policy explained in A-240, Medical Programs.

Exception: An individual received via the Texas Department of Family and Protective Services (DFPS) interface will continue to have a MAGI household size of one. MAGI household size may change at the time of redetermination if additional information is received indicating that additional people should be included in the MAGI household composition.

M-220, Verification Requirements

Body

Revision 15-4; Effective October 1, 2015

There are no verification requirements for household composition. Accept the individual's statement as verification.

M-300, Citizenship

M-310, General Policy

Body

Revision 15-4; Effective October 1, 2015

For most Medicaid for Transitioning Foster Care Youth (MTFCY) applications received via the Texas Department of Family and Protective Services (DFPS) interface, citizenship and alien status has been verified. For MTFCY applications not received via the DFPS interface, a period of reasonable opportunity may be granted if necessary, following the Medical Programs policy for citizenship and alien status eligibility in A-300, Citizenship.

Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for MTFCY if they meet all other eligibility criteria.

M-400, Social Security Number

M-410, General Policy

Body

Revision 20-2; Effective April 1, 2020

All applicants must provide a Social Security number (SSN) or apply for one through the Social Security Administration (SSA) before certification.

The Medicaid for Transitioning Foster Care Youth (MTFCY) program follows the SSN policy in A-400, Social Security Number, under the All Programs or Medical Programs headings.

M-500, Age

M-510, General Policy

Body

Revision 10-2; Effective April 1, 2010

To receive Medicaid for Transitioning Foster Care Youth benefits, individuals must be at least age 18 and younger than age 21. Applicants are eligible to receive benefits from age 18 through the month of their 21st birthday.

M-520, Verification Requirements

Body

Revision 10-2; Effective April 1, 2010

Accept self-declaration as verification of age.

M-530, Documentation Requirements

Body

Revision 10-2; Effective April 1, 2010

Document the individual's self-declaration establishing the age.

M-600, Relationship

Body

Revision 10-2; Effective April 1, 2010

Relationship requirements are not applicable in the Medicaid for Transitioning Foster Care Youth program.

M-700, Identity

M-710, General Policy

Body

Revision 10-2; Effective April 1, 2010

To establish identity, follow Medical Programs policy in A-600, Identity.

M-800, Residence

M-810, General Policy

Body

Revision 15-4; Effective October 1, 2015

To determine residence eligibility, follow TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48 policy in A-700, Residence.

M-900, Adequate Health Coverage (Third-Party Resource)

M-910, General Policy

Body

Revision 15-4; Effective October 1, 2015

An applicant or recipient is not eligible to receive Medicaid for Transitioning Foster Care Youth (MTFCY) benefits if the individual currently has adequate health coverage. Adequate health coverage is also known as a third-party resource (TPR). Adequate health coverage is defined as receiving coverage under:

- group health insurance,
- health insurance coverage,
- Medicare (Part A or Part B),
- Medicaid (with the exception of the Texas Women's Health Program, Medicaid with Spend Down, and Community Attendant),
- Armed Forces insurance, or
- a state health risk pool.

Deny an application for an individual who has adequate health coverage.

Do not consider a plan with a limited scope of coverage such as dental, vision, long-term care, etc., or for only a specific illness/disease such as drug/substance abuse as adequate health coverage.

Consider an applicant/recipient as having adequate health coverage even if it has limits on benefits or high deductibles.

If staff receive a task with information that the individual has TPR and the "NHIC" box is greyed out, advisors deny rather than pend the EDG. This information has already been verified by the Office of Inspector General – Third Party Liability area.

When an MTFCY applicant is denied due to adequate health care coverage, Form TF0001, Notice of Case Action, will read:

"We found that you already have private health insurance. To learn more about the insurance you already get, call toll-free 1-800-846-7307 (after you pick a language, press 2)."

In some instances, the parents of MTFCY recipients have TPR coverage for them without the individual knowing. If the individual states they are not aware of the TPR, staff should advise them to call the claims administrator's Third Party Liability Customer Service Line at 1-800-846-7307 and select option 2. This will allow the individual to obtain information regarding their TPR.

If the TPR information in the Texas Integrated Eligibility Redesign System (TIERS) has been verified by the claims administrator but needs to be updated, staff should fax the completed Form H1039, Medical Insurance Input, to the claims administrator at 512-514-4215.

M-920, Verification Requirements

Body

Revision 10-2; Effective April 1, 2010

Accept self-declaration of adequate health coverage.

Exception: If an applicant is denied due to receiving adequate health coverage and the applicant calls to notify HHSC that the medical insurance is not adequate health coverage, staff would need to verify if the coverage is considered adequate health coverage.

M-930, Documentation Requirements

Body

Revision 10-2; Effective April 1, 2010

Staff must document in case comments the existence of adequate health coverage.

M-1000, Medicaid Eligibility

M-1010, Three Months Prior Coverage

Body

Revision 20-4; Effective October 1, 2020

The person is continuously eligible for 12 months beginning the first day of the application month if all eligibility criteria are met. Applicants are eligible to receive benefits beginning the month of their 18th birthday through the end of the month of their 21st birthday.

The medical effective date cannot precede the month of the applicant's 18th birthday.

Follow policy in B-500, Medical Coverage for Individuals Confined in a Public Institution, for people who are confined in a public institution .

Related Policy

Medical Coverage for Individuals Confined in a Public Institution, B-500

M—1011 Three Months Prior Coverage

Revision 10-2; Effective April 1, 2010

Follow policy in A-830, Medicaid Coverage for the Months Prior to the Month of Application, to provide Medicaid coverage if the individual meets eligibility criteria.

M—1012 Types of Coverage

Revision 15-4; Effective October 1, 2015

The type of coverage determines how recipients access Medicaid services. There are two types of coverage. They are fee-for-service and managed care.

Fee-for-Service — Also known as traditional Medicaid, allows access to any Medicaid provider and self-referral to specialists. The provider submits claims directly to the claims administrator for reimbursement of Medicaid-covered services.

Managed Care — A service delivery program that provides medical care in a managed care setting. The state pays a monthly premium to the health maintenance organization (HMO) for each recipient enrolled in the plan. The plan processes all provider claims.

Medicaid for Transitioning Foster Care Youth recipients have the option to enroll in either type of coverage. See A-821.2, Managed Care.

Related Policy

Types of Coverage, A-821

M-1100, Domicile

Body

Revision 10-2; Effective April 1, 2010

Domicile requirements do not apply to the Medicaid for Transitioning Foster Care Youth program.

M-1200, Deprivation

Body

Revision 10-2; Effective April 1, 2010

Deprivation requirements do not apply to the Medicaid for Transitioning Foster Care Youth program.

M-1300, Child Support

Body

Revision 10-2; Effective April 1, 2010

Child and medical support requirements do not apply to the Medicaid for Transitioning Foster Care Youth program.

M-1400, Resources

Body

Revision 15-4; Effective October 1, 2015

Resources are not considered in determining eligibility for Medicaid for Transitioning Foster Care Youth (MTFCY).

M-1500, Income

M-1510, General Policy

Body

Revision 15-4; Effective October 1, 2015

Medicaid for Transitioning Foster Care Youth (MTFCY) individuals must have income less than or equal to the applicable income limit for TP 70, defined in C-131.1, Federal Poverty Income Limits (FPIL).

Advisors must use Modified Adjusted Gross Income (MAGI) rules to determine financial eligibility for MTFCY following the Medical Programs policy, explained in A-1300, Income.

Exception: Individuals who have had an Interstate Compact on the Placement of Children (ICPC) agreement do not need to meet the income requirement.

M-1600, Deductions

M-1610, General Policy

Body

Revision 10-2; Effective April 1, 2010

Use Medical Programs policy in A-1400, Deductions, to determine which deductions a household is eligible to receive.

M-1700, School Enrollment

Body

Revision 10-2; Effective April 1, 2010

School attendance requirements are not applicable for the Medicaid for Transitioning Foster Care Youth program.

M-1800, Management

Body

Revision 10-2; Effective April 1, 2010

Management requirements are not applicable for the Medicaid for Transitioning Foster Care Youth program.

M-1900, Reminders

M-1910, General Policy

Body

Revision 15-4; Effective October 1, 2015

Before certifying applicants and recertifying recipients, advisors must:

- Ensure the applicant completes each question and signs and dates the application.
- Give the applicant Form H1019, Report of Change. Explain that changes must be reported within 10 days after knowing about the change. Indicate the appropriate reporting requirement on Page 1.
- Refer the applicant to other programs for which the individual might be eligible such as the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Medicaid; Supplemental Security Income (SSI); or Retirement, Survivors and Disability Insurance (RSDI). Refer individuals with a disability who are ineligible for Medical Programs for families and children to the Texas Health and Human Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) programs.
- Inform the applicant of the right to appeal any HHSC action that affects the individual's eligibility.
- Inform the applicant that the information the applicant provides is subject to verification by third parties.

There is no requirement to inform individuals to report accidents.

M-1920, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

Document that form VR30, Texas Voter Registration Application, was given to the applicant, authorized representative or representative payee in the Agency Use Only section of the application.

Related Policy

Registering to Vote, A-1521

M-2000, Case Disposition

Body

M—2010 Notice to Applicants

Revision 15-4; Effective October 1, 2015

When processing an application, redetermination or change, advisors are required to inform the individual if their request is pended, certified, sustained, or denied. Eligibility Determination Group (EDG) disposition is the end result of processing the request for assistance and will generate Form TF0001, Notice of Case Action. However, if the EDG cannot be disposed because it is pending for additional information/verification, the advisor must provide the individual with Form H1020, Request for Information or Action.

Form H1020, Request for Information or Action

Form H1020 informs the individual the:

- reason the case is pending,
- action the individual or advisor must take,
- date by which the individual or advisor must take action, and
- date the advisor must deny the application/case if the individual does not take action, if applicable.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

Form TF0001, Notice of Case Action

TF0001 informs the individual:

- the date benefits begin,
- the date of denial,
- about his/her right to appeal, and
- address and telephone number of free legal services available in the area.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

M—2020 Length of Certification

Revision 25-1; Effective Jan. 1, 2025

The eligibility determination system calculates the eligibility end date from the date staff dispose the EDG as follows:

- Applications – initial certification month plus 11 months.
- Renewals – 12 months from the last certification month.

Recipients are continuously eligible for Medicaid for Transitioning Foster Care Youth benefits for 12 months or through the month of their 21st birthday, whichever is earlier.

Exception: A recipient is not eligible to receive 12 months of continuous eligibility if they:

- start receiving adequate health coverage;
- reach 21 years;
- die;
- voluntarily withdraw; or
- move out-of-state.

Note: A MTFCY recipient remains on MTFCY after a report of pregnancy. If the recipient's MTFCY coverage is denied, including if she ages out of the program, she is transitioned to Medicaid for Pregnant Women (TP 40) for the rest of her pregnancy and 12-month postpartum period.

M—2030 Setting Special Reviews

Revision 10-2; Effective April 1, 2010

Use Medical Programs policy in A-2330, Setting Special Reviews, to set special reviews.

M—2040 Adverse Action

Revision 10-2; Effective April 1, 2010

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations, households may continue receiving benefits pending an appeal. After certification, give households advance notice of adverse actions to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

For adverse action, use current policy in A-2340, Adverse Action.

M-2100, Processing Time Frames

M-2110, Applications

Body

Revision 15-4; Effective October 1, 2015

Advisors must make an eligibility determination by the 45th day from the file date.

Advisors reopen an application denied for failing to furnish information/verification if the missing information is provided by the 60th day from the file date. Use the date the missing information/verification was provided as the new file date.

Advisors use the original application until it is 60 days old.

If the information on the form has changed or is more than 45 days old, the individual and advisor must update the form.

M-2120, Deadlines

Body

Revision 10-2; Effective April 1, 2010

Provide Form TF-0001, Notice of Case Action, the same day eligibility is determined for an application but no later than 45 days from the file date.

M-2130, Missed Interviews

Body

Revision 10-2; Effective April 1, 2010

No interview is required to process an application or renewal unless requested by the applicant/individual. If requested, provide the applicant/individual a telephone interview. If the individual fails to keep the interview, do not deny the application or renewal but continue to process the request for assistance.

M-2140, Pending Information on Applications

Body

Revision 15-4; Effective October 1, 2015

Advisors may not request additional information or documentation from clients unless such information is not available electronically or the information obtained electronically is not consistent with the information provided by the client.

If additional information is needed, advisors must request documents that are readily available to the household and are considered to be sufficient verification. Each handbook section lists potential verification sources. C-900, Verification and Documentation, gives information on verification procedures.

In determining eligibility, advisors must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

M-2150, Notice of Renewal/Expiration

Body

Revision 15-4; Effective October 1, 2015

The system generates and sends renewal correspondence to individuals enrolled in Medicaid for Transitioning Foster Care Youth (MTFCY) following the process explained in B-121, Notice of Redetermination/Certification Expiration, for TP 08 and Children's Medicaid (TP 43, TP 44 and TP 48).

Note: The system will generate Form H1206, Health Care Benefits Renewal – MTFCY, rather than Form H1206, Health Care Benefits Renewal – MA, for individuals renewing MTFCY.

M-2160, Processing Renewals

Body

M—2161 How to Process a Renewal

Revision 15-4; Effective October 1, 2015

MTFCY recipients complete the administrative renewal process explained in B-122.4, Medical Program Administrative Renewals.

Note: If an individual is required to return a renewal form and returns a paper Form H1206, Health Care Benefits Renewal – MTFCY, the form is routed to Centralized Benefit Services (CBS) for processing.

M-2170 Renewal Time Frames

Body

Revision 15-4; Effective October 1, 2015

For individuals required to return a renewal packet, advisors must process the manual renewal as explained in B-122.4.2, Processing a Manual Renewal.

M-2180, Pending Information

Body

Revision 15-4; Effective October 1, 2015

Allow the household at least 10 days to provide missing information/verification. The due date must be a workday. Advisors must request documents that are readily available to the household if the documents are anticipated to be sufficient verification. If the applicant has any active or inactive Eligibility Determination Groups (EDGs), check to see if any verification previously provided for the other EDGs can be used to determine eligibility for MTFCY.

Use verifications accepted for the Temporary Assistance for Needy Families (TANF) program, Medical Programs or the Supplemental Nutrition Assistance Program (SNAP).

For example, if you accept wage verification for a SNAP case, that same verification is acceptable for TANF, Medical Programs or MTFCY.

Exception: Only Medical Programs sources of verification of U.S. citizenship for applicants can be used.

Note: Do not use verification that is over 90 days old from the MTFCY file date.

M—2181 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 15-4; Effective October 1, 2015

Case Action	Due Date	Final Due Date
Application	10 days	• 30th day, or • 10th day if the household's Form H1020 due date extends beyond the 30th day
Renewal	10 days	• 30th day or by cutoff in the last benefit month of certification, whichever is later; or • 10th day if the household's Form H1020 due date extends beyond the last day of the last benefit month
Incomplete review	10 days	10th day

Note: Staff have until the 45th day from the file date to determine eligibility for applications.

M-2200, Changes

M-2210, How to Report a Change

Body

Revision 15-4; Effective October 1, 2015

Centralized Benefit Services (CBS) staff process all changes for Medicaid for Transitioning Foster Care Youth (MTFCY) recipients. MTFCY recipients can report changes:

- online through YourTexasBenefits.com;
- by visiting a local eligibility determination office (which will forward the change to CBS);
- by calling 2-1-1; or

- in writing, by mail or fax, or by completing Form H1019, Report of Change. The individual may mail or fax the change to:
    - Document Processing Center:

HHSC
P.O. Box 149024
Austin, TX 78714-9024
Toll-free fax: 1-877-447-2839

- A local eligibility determination office (which will send the change to CBS).

Note: When a change is reported by telephone, staff must verify that the person speaking is the individual or an authorized representative.

An individual is continuously eligible for MTFCY for 12 months or through the month of his 21st birthday, whichever is earlier.

An individual must report the following changes:

- an address change;
- income, including sources of income, regular hours worked, and pay rate;
- Modified Adjusted Gross Income (MAGI) expenses;
- voluntary withdrawal of the individual;
- receipt of health insurance; or
- if the individual moves out of state.

Process all other changes, including agency-generated changes, at the next renewal.

Exception: If the individual failed to report required information at the time of the application that causes the individual to be ineligible for MTFCY, advisors must deny the benefits and send a fraud referral to the Office of the Inspector General.

M-2220, Action on Changes

Body

Revision 20-4; Effective October 1, 2020

Document all changes or agency generated change tasks received during the 12-month continuous eligibility period and process the change at renewal, except:

- death of the certified person;
- voluntary withdrawal;
- receipt of health insurance;
- moves out of Texas; or
- change of address.

If a change of address is received, mail the person form VR30, Texas Voter Registration Application. If the person contacts CBS or 2-1-1 to decline the opportunity to register to vote after receipt of form VR30, mail Form H1350, Opportunity to Register to Vote, to the person for a signature. File Form H1350 in the case record when the person returns the form and retain the form for at least 22 months.

Follow policy in B-532, Medicaid Reinstatement for Persons Released from Texas County Jails, if a person was incarcerated in a Texas County Jail and Medicaid is suspended.

Follow Medical Programs policy in B-600, Changes, for verification and documentation requirements.

Related Policy
Registering to Vote, A-1521
Medicaid Reinstatement for Persons Released from Texas County Jail, B-532
Changes, B-600

M-2221 Returned Mail

Revision 16-4; Effective October 1, 2016

When returned mail is received, the vendor creates and assigns a Returned Mail (RTML) task to Centralized Benefit Services (CBS) staff for processing.

Upon receipt of the RTML task, CBS staff must take the following actions:

1. Review the address on the returned mail, the case record, and the State Portal to determine whether the household has reported a new address. If a new address has been reported, process the address change and, if there is a Supplemental Nutrition Assistance Program (SNAP) Eligibility Determination Group (EDG), any related changes in shelter expenses.
2. If a new address has not been reported and a forwarding address was not provided, attempt to contact the household via telephone to obtain an updated address and document the attempt. If the household provides a new address, process the address change and, if there is a SNAP EDG, any related changes in shelter expenses. Otherwise go to Step 3.
3. If there is an individual(s) in the household who receives Retirement, Survivor's and Disability Insurance (RSDI) or Supplemental Security Income (SSI), use the State Online Query (SOLQ) to verify the household's address. Use the address in SOLQ to update the address if the address in SOLQ differs from the address on file and, if there is a SNAP EDG, explore shelter expenses.

If the address in SOLQ matches the address in the TIERS record, document in TIERS Case Comments that the SOLQ inquiry address matches the TIERS address and take no further action.

If unable to contact the individual by phone and there is not an individual(s) in the household who receives RSDI or SSI for the:

- MTFCY EDG, go to Step 4; and
- SNAP EDG, follow Step 5 under the process for a case that includes a SNAP EDG in B-638, Returned Mail.

4. If unable to update the address, simultaneously send emails using the following CBS email box to:

- Health Plan Operations (HPO) using the following email box:
  - cbs_ffche-mtfcy@hhsc.state.tx.us and
- Preparation for Adult Living (PAL) using the following email box:
  - OES_FFCC@hhsc.state.tx.us

HPO Process

- Send an email to the Medicaid CHIP Division (MCD) Health Plan Operations (HPO) at HPO_Star_Plus@hhsc.state.tx.us.
- Include in the subject line **Returned Mail – [last four digits of the client's case number]**.
- Include the following information in the email:
  - case name;
  - case number;
  - individual’s date of birth (DOB), Social Security Number (SSN), and Medicaid individual Identification Number; and
  - date the response is needed.
- Leave the RTML task pending.

PAL Process

- Use the link below to identify the Lead Regional PAL staff covering the region of the client's last known address.
  - https://www.dfps.texas.gov/Child_Protection/Youth_and_Young_Adults/Preparation_For_Adult_Living/PAL_coordinators.asp
- Send an email to the identified Lead Regional PAL staff.
- Include in the subject line **Returned Mail -- [last four digits of the client's case number].**
- Include the following information in the email:
  - case name;
  - case number;
  - individual's DOB, SSN, and Medicaid Individual Identification Number; and
  - date the response is needed.
- Leave the RTML task Pending.

Note:

For an individual who aged out of the Unaccompanied Refugee Minor (URM) Resettlement program, contact the following agencies and individuals to determine if the agency or individual has an updated address for the former URM:

- The URM's former Voluntary Agency (VolAg); and
- The two agencies in Texas that have URM programs:
  - Catholic Charities Diocese of Fort Worth
    - Jennifer Frazier, URM Director, at jfrazier@ccdofw.org
- Catholic Charities Diocese of Galveston-Houston
  - Debbie Sandberg, URM Coordinator, at 713-874-6505 or dsandberg@catholiccharities.org
  - Raj Kendrick, URM Director, at 281-874-6530 or rkendrick@catholiccharities.org

5. The MCD HPO and DFPS PAL staff have ten calendar days to respond. It is important that staff make the request as soon as possible. The response will include either:

- the known address on file for the individual; or
- no known address on file for the individual.

MCD HPO responds to the CBS email mailbox (cbs_ffche-mtfcy@hhsc.state.tx.us) and copies the original requestor with information from the plan by the tenth calendar day from when the email is sent, either confirming or denying that they have an address on file for the client. If they confirm, the response will include the address on file.

The **DFPS PAL** program responds to the email box (OES_FFCC@hhsc.state.tx.us) and copies the original requestor with information from the Lead Regional PAL staff by the tenth calendar day from when the email is sent, either confirming or denying that they have an address on file for the client. If they confirm, the response will include the address on file.

Note: If the MCD HPO and DFPS PAL both respond and provide different addresses, use the address received from the MCD HPO (unless the individual has already provided an address).

6. For cases with a SNAP EDG, if by the Form H1020 due date, the household:

- provides the requested information, process the address change for all active EDGs, including the MTFCY EDG, and address any related changes in shelter expenses for the SNAP EDG; or
- fails to provide the requested information, deny the SNAP EDG for failure to provide information. Send Form TF0001, Notice of Case Action, using the denial reason, "Failed to Provide Information".

For the MTFCY EDG, if by the tenth calendar day due date the HPO/PAL information:

- is provided, use the information to update the address in the TIERS record; or
- is not provided, use the following steps to deny the EDG(s) using the denial reason "Unable to Locate" as stated in A-2344.1, Form TF0001 Required (Adequate Notice).
    - In Change Action Mode, go to "Household Information" and select "Yes" for the question "is the worker unable to locate the household?"
    - Run eligibility.

Note: The HPO/PAL information cannot be used to verify residence for SNAP EDGs.

7. If MCD HPO or DFPS PAL provide an updated address within 30 days of the EDG's denial due to "Unable to Locate," reopen the EDG.

For the SNAP EDG, if the household is denied for failure to provide information and provides a correct address within the advance notice adverse action period, reopen the EDG using the original certification period and process any related changes in shelter expenses. Please refer to the TIERS Advance Notice of Adverse Action Reference Guide in the ASK iT Knowledge Base for instructions.

Notes:

- If an address provided by MCD HPO or the DFPS PAL program differs from an address provided by the household, contact the household to resolve the discrepancy.
- For SNAP EDGs, if the household provides verification of residence, but does not provide information regarding shelter expenses, re-budget eligibility without the shelter expense and notify the household, according to policy in A-631, Actions on Changes.

Related Policy

Actions on Changes, B-631
Returned Mail, B-638

M-2300, Fair Hearings

M-2310, Appeals Procedures

Body

Revision 10-2; Effective April 1, 2010

Medicaid for Transitioning Foster Care Youth applicants or recipients receiving a notice of adverse action are not entitled to continued benefits when benefits are denied for any reason if doing so would extend the 12-month continuous eligibility period or benefits past their 21st birthday.

See B-1000, Fair Hearings, for specific appeals policy and procedures.

M-2400, Automated Support

M-2410, Data Broker

Body

Revision 15-4; Effective October 1, 2015

Advisors must follow the policy explained in C-817, Electronic Data Sources (ELDS), and C-820, Data Broker.

Exception: The consent policy explained in C-817 does not apply to individuals that are transferred to the Texas Health and Human Services Commission (HHSC) via the Texas Department of Family and Protective Services (DFPS) interface.

Part R, Refugee Medical Assistance

Body

Revision 17-2; Effective April 1, 2017

Effective February 1, 2017, HHSC no longer determines eligibility for Refugee Medical Assistance (RMA) and benefits provided to Unaccompanied Refugee Minors (URM's) under Former Foster Care Children (FFCC) or Medicaid for Transitioning Foster Care Youth (MTFCY).

Part W, Healthy Texas Women

W-100, Application Processing

W-110, Healthy Texas Women (HTW)

Body

Revision 22-3; Effective July 1, 2022

HTW provides for a continuous 12-month certification period with the following limited health care benefits:

- Annual family planning exams
- Family planning counseling and education
- Treatment of certain sexually transmitted infections
- Birth control (except emergency birth control), including methods to permanently prevent pregnancy (tubal ligations or Essure)
- Follow-up family planning visits related to the method of birth control

Note: For people 15-17, a parent or legal guardian's signature is required.

HTW Plus (HTW+)

Enhanced and limited postpartum care services are available to HTW members whose pregnancies ended within the 12 months preceding their enrollment into HTW.

Enhanced postpartum benefits include services that address:

- postpartum depression and other mental health conditions;
- cardiovascular and coronary conditions; and
- substance use disorders, including drug, alcohol and tobacco use.

There is no separate eligibility determination for HTW+. If a woman is determined eligible for HTW and her pregnancy ended within the 12 months before her HTW eligibility date, she is eligible for HTW+ benefits during her 12-month HTW certification period. TIERS automatically adds an HTW+ indicator flag to the woman’s HTW EDG.

W-111 Type of Assistance (TA) 41 – MA – Healthy Texas Women

Revision 24-4; Effective Oct. 1, 2024

To be eligible for HTW, applicants must:

- be female, 15 through 44;
  - a parent or legal guardian **must** apply on behalf of applicants 15-17;
- have countable income of less than or equal to 204.2% of the federal poverty level;
- be a U.S. citizen or a legally admitted alien who meets all eligibility requirements for Medicaid;
- be a Texas resident;
- not be pregnant;
- not have creditable health insurance that covers family planning services; and

- not currently receive Medicaid, Medicare Part A or B, or Children's Health Insurance Program benefits. Receipt of Medicare Part B-ID does not affect eligibility for HTW benefits.

Notes:

- A legal guardian is a person appointed by a judge to care for a child younger than 18.
- Deny applications received for minors, 15-17, without a parent or legal guardian signature if they are not eligible for full coverage Medicaid or CHIP. Use the denial reason, Denied 15-17 without parent or legal guardian's signature.
- Married minors, 15-17, are not eligible for HTW. Deny applications for married minors if they are not eligible for full coverage Medicaid or CHIP. Use the denial reason, Denied 15-17 married minors.

Related Policy

Income Limits, C-131
General Policy, W-510

W-112 Application Procedures

Revision 21-3; Effective July 1, 2021

Applicants can use any Texas Works medical benefits application form to apply for HTW.

Related Policy

Application Requests and Submissions, A-113

W-113 Requesting an Application

Revision 21-3; Effective July 1, 2021

Applicants can request and submit an application using any of the medical program application channels.

If an applicant applies in-person at a local office or through participating family planning providers or other community-based organizations and requests help completing an application, a volunteer or staff member must give help and initial the parts completed or sign the application to show the applicant received help.

Related Policy

Application Requests and Submissions, A-113

W-120, Office Procedures

Body

W-121 Reserved for Future Use

Revision 21-3; Effective July 1, 2021

W-122 Telephonic Signatures

Revision 25-3; Effective July 1, 2025

All Programs

An applicant or designated authorized representative (AR) can complete and sign an application using a telephonic signature.

Related Policy

Receipt of Application, A-121
Application Signature, A-122.1

W-123 File Date

Revision 21-3; Effective July 1, 2021

Follow policy for medical programs to determine if the application is valid and the application's file date.

Document why a certain file date was used to determine eligibility when:

- a file date differs from the received date on the application; or
- the application has two received dates (stamp dates).

Related Policy

Receipt of Application, A-121
Filing the Application, A-122
General Policy, W-910

W-124 Faxed Applications

Revision 21-3; Effective July 1, 2021

The file date for faxed applications is the day the application is received by the HHSC fax line.

Verbally inform the applicant or provider to fax the confirmation page and original application to determine the correct file date when: an applicant or provider states that an application was faxed to the HHSC fax line; but the fax was not received.

If HHSC receives the fax confirmation page and the original application:

- Within 30 days of the submission of the original application, the file date is the submission date as shown on the fax confirmation page. Use the date printed by the fax machine to verify the original submission date.
- More than 30 days after the original submission date, the file date is the date the application is resubmitted.

W-130, Interviews

Body

W—131 General Policy

Revision 17-2; Effective April 1, 2017

An interview is not required when applying for or renewing an application for HTW. Schedule a telephone interview only if the individual requests an interview. Process an application or renewal by mail or telephone.

Note: Do not deny the application if the applicant misses the interview; continue determining eligibility.

W-200, Household Composition

W-210, General Policy

Body

Revision 21-3; Effective July 1, 2021

Follow the Texas Works medical programs household composition policy to determine household composition.

Related Policy

General Policy, A-210

W—211 Budget Group

Revision 21-3; Effective July 1, 2021

Follow the Texas Works medical programs budget policy to determine the applicant's budget group.

Related Policy

Budget Group, A-241

W—212 Certified Group

Revision 17-2; Effective April 1, 2017

Treat women age 18 as adults. The certified group consists only of the woman (adult or minor) applying, and there can only be one certified woman on an HTW EDG. Do not certify an incarcerated woman or married minors.

W-220, Verification Requirements

Body

W—220 Verification Requirements

Revision 21-3; Effective July 1, 2021

Follow the Texas Works medical programs policy for verification requirements.

Related Policy

Verification Requirements, A-250

W-300, Citizenship

Body

W-310, General Policy

Body

Revision 20-3; Effective July 1, 2020

The Healthy Texas Women (HTW) program follows the Medical Programs citizenship policy in A-300, Citizenship.

Applicants, who are U.S. citizens and certain legally admitted alien residents, are eligible for HTW if they meet all other eligibility criteria.

Related Policy

Citizenship, A-300

W-400, Social Security Number

Body

W-410, General Policy

Body

Revision 20-2; Effective April 1, 2020

All applicants must provide a Social Security number (SSN) or apply for one through the Social Security Administration (SSA) before certification.

The Healthy Texas Women (HTW) program follows the SSN policy in A-400, Social Security Number, under the All Programs or Medical Programs headings.

W-500, Age

W-510, General Policy

Body

Revision 21-3; Effective July 1, 2021

To receive Healthy Texas Women (HTW) benefits, the recipient must be 15 through 44. An applicant is considered 15 the month of her 15th birthday and age 44 through the month of her 45th birthday. A parent or legal guardian must apply on behalf of minors 15 through 17.

Ten days prior to a woman turning 18 years old, she will receive Form H1871, HTW Client Turning 18 Years Old, to inform her she is now responsible for managing her own HTW Eligibility Determination Group (EDG). The form also provides information about how to report a confidential address.

Married minors are not eligible for HTW; the TF0001 will inform the minor of other services they may be eligible to receive.

Examples:

In these examples, the applicant has already been determined ineligible for full coverage Medicaid and the Children's Health Insurance Program (CHIP) and is now being tested for HTW eligibility.

- A woman turns 15 on Feb. 9. Her parent filed an application on Jan. 17. The woman is ineligible to receive HTW as she is not turning 15 in the application month. A parent or legal guardian must reapply in the month of February to meet the age requirements.
- A woman turns 18 on July 27. Her parent filed an application on June 5. The woman is eligible for HTW if other eligibility criteria are met. Ten days prior to her 18th birthday on July 17, Form H1871 is generated to inform her once she turns 18 she is responsible for managing her own HTW EDG.
- A woman turns 45 on May 5. She will no longer be eligible to receive HTW benefits effective June 1.

Age is self-declared. If questionable, verify the applicant's age using the Bureau of Vital Statistics (BVS). If unable to verify using BVS, attempt to contact the applicant to clear the discrepancy. Use information provided by the applicant on a previous EDG, if possible.

If the applicant is not eligible for full coverage Medicaid or CHIP and the application is received in a month the applicant:

- is 14, and the application is processed in a month she becomes 15, deny the application because of age;
- is 44, and the application is processed in a month she becomes 45, if otherwise eligible, certify for the month of application and the month of her 45th birthday; or
- becomes 45, and the application is processed the month after her 45th birthday, if otherwise eligible, certify for the month of application only.

Use the following denial reason:

- **English** — You do not meet the age requirement for the Healthy Texas Women program. To receive benefits under this program, you must be 15 through 44 years of age.
- **Spanish** — Usted no llena los requisitos de edad del programa Healthy Texas Women. Para recibir beneficios bajo este programa, tiene que tener entre 15 y 44 años de edad.

Married minors 15 through 17 are not eligible for HTW. If the married minor is not eligible for Medicaid and CHIP, use the denial reason, "Denied 15-17 married minors" for HTW. The TF0001, Notice of Case Action, will include the following language:

English:

Notice Language –You are not able to get Healthy Texas Women services because you are an emancipated minor. You might be able to get services through other programs:

Medicaid or CHIP. Apply by: (1) going to YourTexasBenefits.com or (2) calling 2-1-1 or 877-541-7905 for an application (after you pick a language, press 2).

Family Planning Program services. Apply by: (1) going to HealthyTexasWomen.org or (2) calling 2-1-1 or 877-541-7905 (after you pick a language, press 2).

Spanish:

Notice Language – Usted no puede recibir servicios de Healthy Texas Women porque es una menor de edad emancipada. Es posible que usted pueda recibir servicios a través de otros programas:

Medicaid o CHIP. Para hacer la solicitud: (1) vaya a YourTexasBenefits.com o (2) llame al 2-1-1 o al 877-541-7905 para pedir una solicitud (después de seleccionar un idioma, oprima el 2).

Servicios del Programa de Planificación Familiar. Para hacer la solicitud: (1) vaya a HealthyTexasWomen.org o (2) llame al 2-1-1 o al 877-541-7905 (después de seleccionar un idioma, oprima el 2).

When a minor between 15 and 17 submits an application without a parent or guardian and the minor is not eligible for Medicaid or CHIP, use the denial reason of, “Denied 15 -17 without parent or legal guardian’s signature”. The TF0001, Notice of Case Action will include the following language:

Notice Language–You are not able to get Healthy Texas Women services. A parent or legal guardian must apply for young women ages 15 to 17 -- that was not done in this case. You might be able to get services through other programs:

Medicaid or CHIP. Apply by: (1) going to YourTexasBenefits.com or (2) calling 2-1-1 or 877-541-7905 for an application (after you pick a language, press 2).

Family Planning Program services. Apply by: (1) going to HealthyTexasWomen.org or (2) calling 2-1-1 or 877-541-7905 (after you pick a language, press 2).

Spanish:

Notice Language – Usted no puede recibir servicios de Healthy Texas Women. Uno de los padres o un tutor deben llenar la solicitud para jovencitas de 15 a 17 años, lo cual no se hizo en este caso. Es posible que usted pueda recibir servicios a través de otros programas:

Medicaid o CHIP. Para hacer la solicitud: (1) vaya a YourTexasBenefits.com o (2) llame al 2-1-1 o al 877-541-7905 para pedir una solicitud (después de seleccionar un idioma, oprima el 2).

Servicios del Programa de Planificación Familiar. Para hacer la solicitud: (1) vaya a HealthyTexasWomen.org o (2) llame al 2-1-1 o al 877-541-7905 (después de seleccionar un idioma, oprima el 2).

Related Policy

Verification Sources, A-531
Reuse of an Application Form After Denial, B-111

W-520, Verification Requirements

Body

Revision 07-0; Effective July 1, 2007

Accept self-declaration as verification of age.

W-530, Documentation Requirements

Body

Revision 07-0; Effective July 1, 2007

Document the individual's self-declaration establishing her age.

W-600, Relationship

W-610, General Policy

Body

Revision 21-3; Effective July 1, 2021

Follow the Texas Works medical programs budget group policy to determine who is included in the budget group.

Related Policy

Medical Programs, A-240
Budget Group, A-241

W-620, Verification Requirements

Body

Revision 07-0; Effective July 1, 2007

Accept self-declaration as verification for establishing relationship.

W-630, Documentation Requirements

Body

Revision 07-0; Effective July 1, 2007

Advisors must document the individual's self-declaration for establishing relationship.

W-700, Identity

W-710, General Policy

Body

Revision 13-1; Effective January 1, 2013

To establish identity, follow policy for Medical Programs in A-600, Identity.

W-800, Residence

W-810, General Policy

Body

Revision 17-2; Effective April1, 2017

The Healthy Texas Women (HTW) program follows Children's Medicaid policy in A-700, Residence, to determine acceptable residence eligibility.

W-900, Health Care Eligibility

W-910, General Policy

Body

Revision 21-3; Effective July 1, 2021

A woman is continuously eligible for 12 months beginning the first day of the month all eligibility criteria are met. There is no three months prior eligibility for the Healthy Texas Women (HTW) program.

Note: An HTW applicant can apply for and receive three months prior benefits under another Medicaid program (e.g. Medically Needy with Spend Down).

The medical effective date (MED) cannot precede the month of the woman's 15th birthday.

Follow applicable policy if the woman is confined in any public institution.

HTW is a fee-for-service program. Fee-for-service allows access to any health care provider and self-referral to specialists. The provider submits claims directly to the claims administrator for reimbursement of covered services.

If a household fails to report required information at the time of the application that causes the woman to be ineligible for HTW, deny the case.

HTW uses an administrative renewal process.

Note: Women are eligible to receive HTW during their Pay for Performance forfeit month(s).

Related Policy

Pay for Performance, A-2150
Medical Program Administrative Renewals, B-122.4
Termination of Medical Coverage for People Confined in a Public Institution, B-510
Eligibility Begin Dates, W-1920

W-911 Current Medicaid, Medicare (Part A or B) and Children's Health Insurance Program (CHIP) Recipients

Revision 22-3; Effective July 1, 2022

A woman is not eligible to receive HTW benefits if she is currently receiving another type of Medicaid, Medicare (Part A or B) or CHIP.

Note: HTW can briefly overlap full coverage Medicaid in the following situations:

- HTW and Medicaid for Pregnant Women (TP 40): If a woman certified for HTW reports her pregnancy, HTW and TP 40 coverage may overlap because HTW does not provide prenatal or pregnancy benefits. Terminate HTW coverage prospectively and certify TP 40 beginning the first of the month the woman meets all eligibility criteria.
- HTW and Medically Needy with Spend Down (TP 56): HTW and TP 56 coverage may overlap if the HTW woman has unpaid medical bills because HTW does not provide full coverage benefits. HTW coverage is sustained in this scenario.
- HTW and Medicaid for Breast and Cervical Cancer (MBCC): If a woman certified for HTW becomes eligible for MBCC, there may be an overlap in coverage for the month she applies for MBCC. MBCC eligibility begins the date an applicant meets all eligibility criteria and cannot precede the day after the diagnosis date. After the woman is determined eligible for MBCC, terminate HTW prospectively.

When determining HTW eligibility after a woman is determined ineligible for full Medicaid and CHIP, verify via State Online Query (SOLQ) that the applicant is not currently enrolled in Medicare (Part A or B).

If an HTW applicant is actively receiving Medicare (Part A or B) deny the application using the following disposition denial reason:

- **English** — You are ineligible to receive Healthy Texas Women services as you are currently receiving assistance under Medicare.
- **Spanish** — Usted no llena los requisitos para recibir los servicios del Healthy Texas Women ya que actualmente recibe ayuda de Medicare.

Related Policy

Regular Medicaid Coverage, A-820
Pregnant Women, W-912
Eligibility Begin Dates, W-1920
Medicaid Coverage, X-920
Medicaid Effective Date (MED), X-921

W-912 Pregnant Women

Revision 22-3; Effective July 1, 2022

Pregnant women cannot receive HTW benefits. If the applicant does not answer the question “Are you pregnant?”, pend the application and allow the applicant normal processing time frames to provide an answer to the pregnancy question. Accept the applicant’s statement as verification. Deny the application for failure to provide verification if the applicant does not provide an answer to the question “Are you pregnant?”.

If the woman reports a pregnancy on her application, determine if she meets eligibility requirements for Medicaid for Pregnant Women (TP 40) or CHIP-Perinatal (CHIP-P).

If the HTW recipient reports a pregnancy during her 12-month continuous coverage period, determine if she meets eligibility requirements for TP 40 or CHIP-P. Do not require the recipient to complete a new application. If the HTW recipient meets the eligibility requirements for TP 40, allow her to receive HTW and TP 40 in the same month since HTW does not provide full coverage benefits. TIERS will deny the HTW EDG prospectively once the recipient is certified for TP 40 coverage.

Related Policy

Processing Applications for Pregnant Women, A-128
Regular Medicaid Coverage, A-820

W-913 Third-Party Resource (TPR)

Revision 22-4; Effective Oct. 1, 2022

A woman cannot receive HTW benefits when she has creditable health coverage. Creditable health coverage is private health insurance that covers family planning services.

Private health insurance covers family planning services if it provides **both**:

- family planning-related physician office visits and procedures; **and**
- contraceptive drugs and devices.

In making this determination, only consider if the private health insurance provides coverage and do not consider other issues such as high deductibles or dollar limits on drug coverage.

Applications for medical programs ask the following questions:

1. Does the health insurance cover family planning services?
2. If yes: If we file a claim on your health insurance will it cause you physical, emotional, or other harm from your spouse, parents or other person?
3. If yes: Tell us why filing a claim with your health insurance would cause you harm.

Note: A person applying for HTW with creditable health coverage is eligible to receive HTW benefits **only** if identifying and providing information to assist in pursuing third parties is against her best interest.

When determining HTW eligibility after the woman has been determined ineligible for full Medicaid and CHIP:

- Pend the person applying for HTW if she does not answer question 1, question 2 or both.
- Allow the person applying for HTW normal processing time frames to provide an answer. Verification is self-declared by the person applying for HTW.
- If the person applying for HTW does not self-declare the answer to question 1, question 2 or both by the deadline, deny the application for failure to provide.

Note: TPR questions must be addressed at application and renewal.

If the person applying for HTW states **Yes** to question 1 and question 2 but leaves question 3 blank, do not pend the person applying for HTW for an answer. Continue determining eligibility.

If the person applying for HTW states **Yes** to question 1 and **No** to question 2, deny the application using the following denial reason code and add the statement below to the comment section of Form TF0001, Notice of Case Action.

- **English** — On your application you told us you are covered by other health insurance. Women who are covered by other health insurance cannot receive Healthy Texas Women benefits.
- **Spanish** — En la solicitud, usted nos dijo que tiene cobertura de otro seguro médico. Las mujeres con cobertura de otro seguro médico no pueden recibir beneficios del programa Healthy Texas Women.

If the person receiving HTW reports having creditable health insurance during the 12-month continuous coverage period, record the change and take action on the TPR information at the next renewal.

W-914 Automatic Eligibility Determination for HTW

Revision 26-2; Effective April 1, 2026

HTW is part of the Modified Adjusted Gross Income (MAGI) cascade. All women are automatically tested for HTW eligibility when they are determined ineligible for other MAGI Medicaid programs and CHIP unless they opt out.

Women can opt out of the automatic HTW eligibility determination by showing on their initial or renewal application they want to waive HTW testing.

Run the full MAGI cascade when processing the following alerts. Refer the woman to the Marketplace and test her for HTW eligibility if the cascade results in a denial of Medicaid and CHIP because she does not meet eligibility requirements.

- Alert 819, CHIP Child Aging Out Test MAGI
- Alert 823, MA Child Aging Out Test MAGI
- Alert 824, Pregnancy Ending Test MAGI
- Alert 825, Transitional MA Ending Test MAGI
- Alert 903, Test MAGI – Individual Aging out of TP 70 or TA 82

Note: Women receiving Medicaid for Pregnant Women (TP 40) are tested for HTW eligibility at the end of their TP 40 certification period. This is even if they voluntarily withdraw from Medicaid for Parents and Caretaker Relatives (TP 08), including before an eligibility determination is made.

When transitioning to HTW from another MAGI Medicaid program or CHIP, the effective date of the HTW EDG is the first day of the month after the end of the previous benefit's certification period.

When a woman is determined eligible for HTW, TIERS generates:

- Form TF0001, Notice of Case Action; and
- Form H1872, HTW Opting Out and Reporting Confidential Address.

Form H1872 provides the HTW recipient an opportunity to voluntarily withdraw or opt out, and report a confidential address. Form TF0001 and H1872 are addressed to the HTW recipient and mailed to the:

- confidential address; or
- case address if a confidential address was not provided.

Related Policy

Confidentiality, W-2400

W-920, Verification Requirements

Body

Revision 17-2; Effective April 1, 2017

Accept self-declaration of pregnancy and TPR.

W-930, Documentation Requirements

Body

Revision 07-0; Effective July 1, 2007

For TPR, staff must document in case comments:

- the availability of TPR for family planning services;
- if filing a claim would cause physical, emotional or other harm to the individual; and
- why, if provided.

W-1000, Domicile

W-1010, General Policy

Body

Revision 21-3; Effective July 1, 2021

Domicile requirements do not apply to the Healthy Texas Women (HTW) program.

Related Policy

General Policy, A-910

W-1020, Verification Requirements

Body

W—1020 Verification Requirements

Revision 07-0; Effective July 1, 2007

Accept self-declaration as verification of domicile.

W-1100, Deprivation

Body

Revision 17-2; Effective April 1, 2017

Deprivation does not apply to Healthy Texas Women (HTW).

W-1200, Child Support

Body

Revision 17-2; Effective April 1, 2017

Child and medical support requirements do not apply to Healthy Texas Women (HTW).

W-1300, Resources

W-1310, General Policy

Body

Revision 17-2; Effective April 1, 2017

Resources are exempt for Healthy Texas Women (HTW). However, staff must remember to verify income, such as royalties, dividends or interest generated by a resource.

W-1400, Income

W-1410, General Policy

Body

Revision 21-3; Effective July 1, 2021

Use Modified Adjusted Gross Income (MAGI) rules to determine financial eligibility for Healthy Texas Women (HTW) following the Texas Works medical programs policy.

Related Policy

Income, A-1300

W—1411 Types of Income

Revision 21-3; Effective July 1, 2021

Use the Texas Works medical programs policy to determine the countable and exempt income types for HTW.

Related Policy

Types of Income, A-1320

W—1412 Types of Payments

Revision 21-3; Effective July 1, 2021

Use the Texas Works medical programs policy to determine if a payment is countable or exempt for HTW.

Related Policy

Types of Payments, A-1330

W—1413 Income Limits

Revision 21-3; Effective July 1, 2021

Use income limit for HTW (TA 41).

Related Policy

Federal Poverty Level (FPL), C-131.1

W—1414 Calculating Household Income

Revision 21-3; Effective July 1, 2021

Use the Texas Works medical programs policy to calculate household income.

Related Policy

Income Limits and Eligibility Tests, A-1341
Calculating Household Income, A-1350

W—1415 Determining Countable Income in Special Household Situations

Revision 21-3; Effective July 1, 2021

Use the Texas Works medical programs policy to calculate household income in special household situations.

Related Policy

Determining Countable Income in Special Household Situations, A-1360

W-1420, Reserved for Future Use

Body

Revision 21-3; Effective July 1, 2021

W-1430, Income Verification

Body

Revision 21-3; Effective July 1, 2021

Follow the Texas Works medical programs policy, including reasonable compatibility, to verify income.

Related Policy

Verification Requirements, A-1370
Verification Sources, A-1371

W-1440, Documentation Requirements

Body

Revision 21-3; Effective July 1, 2021

Follow the Texas Works medical programs policy for documenting income.

Related Policy

Documentation Requirements, A-1380

W-1500, Deductions

W-1510, General Policy

Body

Revision 21-3; Effective July 1, 2021

Use Modified Adjusted Gross Income (MAGI) rules and the Texas Works medical programs policy to determine allowable deductions for Healthy Texas Women (HTW).

Related Policy

General Policy, A-1410

W—1511 Rules That Apply to Deductions

Revision 21-3; Effective July 1, 2021

Use MAGI rules and the Texas Works medical programs policy to determine allowable deductions for HTW.

Related Policy

Rules That Apply to Deductions, A-1411

W—1512 Types of Deductions

Revision 21-3; Effective July 1, 2021

Use MAGI rules and the Texas Works medical programs policy to determine allowable deductions for HTW.

Related Policy

General Policy, A-1410

W-1520, Verification Requirements

Body

Revision 21-3; Effective July 1, 2021

Use the Texas Works medical programs policy to verify allowable deductions for HTW.

Related Policy

Verification Requirements, A-1440

W-1530, Documentation Requirements

Body

Revision 21-3; Effective July 1, 2021

Use the Texas Works medical programs policy to document allowable deductions for HTW.

Related Policy

Documentation Requirements, A-1450

W-1600, School Attendance

Body

Revision 17-2; Effective April 1, 2017

School attendance requirements are not applicable for Healthy Texas Women (HTW).

W-1700, Management

Body

Revision 17-2; Effective April 1, 2017

Management requirements are not applicable for Healthy Texas Women (HTW).

W-1800, Reminders

W-1810, General Policy

Body

Revision 21-3; Effective July 1, 2021

Before certifying or recertifying a woman for Healthy Texas Women (HTW), ensure the applicant completes each question and signs and dates their application or renewal form.

Note: HTW applications and renewals may have a telephonic signature when the woman calls 2-1-1 and applies for or renews eligibility for HTW.

- During processing or during an interview, note if the applicant indicates changes on the application. Document the nature of the change and when the change is expected to occur.
- Give the applicant Form H1019, Report of Change. Explain that they must report address changes within 10 days after knowing about the change. Indicate the appropriate reporting requirement on page one.
- Refer the applicant to other programs she might be eligible for such as:
  - the Supplemental Nutrition Assistance Program (SNAP);
  - Temporary Assistance for Needy Families (TANF);
  - Family Planning;
  - Supplemental Security Income (SSI); and
  - Women, Infants and Children (WIC); and Social Security.
- Refer people with disabilities or people who are 65 and older and ineligible for Medical Programs for families and children to the Texas Health and Hu man Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) program.
- Inform the applicant of her right to appeal any HHSC action that affects her eligibility.
- Inform the applicant that the information she provides is subject to verification by third parties.

There is no requirement to inform people to report accidents.

Related Policy

Application Signatures, A-122.1
General Reminders, A-1510

W-1820, Documentation Requirements

Body

Revision 21-3; Effective July 1, 2021

Document that form VR30, Texas Voter Registration Application, was given to the applicant in the Agency Use Only section of her application form.

Related Policy

Registering to Vote, A-1521

W-1900, Case Disposition

Body

Revision 21-3; Effective July 1, 2021

W—1910 Notice to Applicants

Revision 21-3; Effective July 1, 2021

Case disposition is the woman's notice of eligibility status. At the end of the interview or during the processing of the woman's application, give her one or more of the following notices as appropriate. If the case is:

- pended;
- certified;
- sustained; or
- denied.

Form H1020, Request for Information or Action, which informs the woman of the:

- reason the case is pending;
- action she or HHSC staff must take;
- date by which she or HHSC staff must take action; and
- date staff must deny the application or case if she does not take action, if applicable; or

Form TF0001, Notice of Case Action, which informs the woman of the:

- date benefits begin;
- date of denial;
- right to appeal; and
- address and phone number of free legal services available in the area.

Women who transition to Healthy Texas Women (HTW) from another Medicaid program or the Children's Health Insurance Program (CHIP) receive Form H1872, HTW Opting Out and Reporting Confidential Address, along with Form TF0001. The Form H1872 informs the woman of the:

- options to voluntary withdraw from HTW; and
- process to report a confidential address.

HTW recipients turning 18 years old receive Form H1871, HTW Client Turning 18 Years Old, ten days prior to their 18th birthday. This informs the woman of:

- the process to report a confidential address; and
- their responsibility to manage their HTW benefits.

Note: For women who only speak Spanish, ensure that all comments provided are in Spanish.

W—1920 Eligibility Begin Dates

Revision 21-3; Effective July 1, 2021

The applicant is eligible the first day of the file date month or, if ineligible the month of application for certain reasons, the first day of the month following the month of application.

Women who transition into HTW from another Medicaid program or CHIP have an effective date of the first day of the month following the end of their previous certification period.

Example: If the TP 40, Medicaid for Pregnant Women, certification end date is Sept. 30, then the HTW effective date is Oct. 1.

A woman is ineligible to receive HTW benefits if she applies the month after her 45th birthday.

Related Policy

Current Medicaid, Medicare (Part A or B) and Children's Health Insurance Program (CHIP) Recipients, W-911

W—1930 Length of Certification

Revision 17-2; Effective April 1, 2017

The Texas Integrated Eligibility Redesign System (TIERS) calculates an end date from the date the advisor certifies the application/renewal as follows:

- Applications — initial certification month plus 11 months.
- Renewals — 12 months from the last certification month.

Women are continuously eligible for Healthy Texas Women benefits for 12 months or through the month of the woman's 45th birthday, whichever is earlier.

Exception: A woman does not receive her 12 months of continuous eligibility if she:

- is found eligible for Medicaid, Medicare (Part A or B) or the Children's Health Insurance Program;
- dies;
- voluntarily withdraws; or
- moves out of Texas.

W—1940 Setting Special Reviews

Revision 07-0; Effective July 1, 2007

Do not set a special review even if a known change is to occur during the woman's 12-month continuous eligibility period. Document the known change and use the information at the next renewal. Follow current procedures and report the known change if the applicant has other active Eligibility Determination Group cases.

W—1950 Adverse Action

Revision 15-4; Effective October 1, 2015

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations, households may continue benefits pending an appeal. After certification, give households advance notice of adverse actions to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

For adverse action, use current policy in A-2340, Adverse Action.

W-1910, Notice to Applicants

Body

Revision 22-4; Effective Oct. 1, 2022

At the end of the interview or during the processing of the woman's application, give her one or more of the following notices as appropriate. If the case is:

- pended;
- certified;
- sustained; or
- denied.

Form H1020, Request for Information or Action, to inform the woman of the:

- reason the case is pending;
- action she or HHSC staff must take;
- date by which she or HHSC staff must take action; and
- date staff must deny the application or case if she does not take action, if applicable; or

Form TF0001, Notice of Case Action, to inform the woman of the:

- date benefits begin;
- date of denial;
- right to appeal; and
- address and phone number of free legal services available in the area.

Note: Form TF0001 for HTW only includes information about HTW benefits and is sent separately from the TF0001 for other benefits.

Women who transition to Healthy Texas Women (HTW) from another Medicaid program or the Children's Health Insurance Program (CHIP) receive Form H1872, HTW Opting Out and Reporting Confidential Address, along with Form TF0001. The Form H1872 informs the woman of the:

- options to voluntary withdraw from HTW; and
- process to report a confidential address.

HTW recipients turning 18 years old receive Form H1871, HTW Client Turning 18 Years Old, ten days before their 18th birthday. The Form H1871 informs the woman of:

- the process to report a confidential address; and
- their responsibility to manage their HTW benefits.

Note: For women who only speak Spanish, ensure that all comments provided are in Spanish.

W-1920, Eligibility Begin Dates

Body

Revision 21-3; Effective July 1, 2021

The applicant is eligible the first day of the file date month or, if ineligible the month of application for certain reasons, the first day of the month following the month of application.

Women who transition into HTW from another Medicaid program or CHIP have an effective date of the first day of the month following the end of their previous certification period.

Example: If the TP 40, Medicaid for Pregnant Women, certification end date is Sept. 30, then the HTW effective date is Oct. 1.

A woman is ineligible to receive HTW benefits if she applies the month after her 45th birthday.

Related Policy

Current Medicaid, Medicare (Part A or B) and Children's Health Insurance Program (CHIP) Recipients, W-911

W-1930, Length of Certification

Body

Revision 17-2; Effective April 1, 2017

The Texas Integrated Eligibility Redesign System (TIERS) calculates an end date from the date the advisor certifies the application/renewal as follows:

- Applications — initial certification month plus 11 months.
- Renewals — 12 months from the last certification month.

Women are continuously eligible for Healthy Texas Women benefits for 12 months or through the month of the woman's 45th birthday, whichever is earlier.

Exception: A woman does not receive her 12 months of continuous eligibility if she:

- is found eligible for Medicaid, Medicare (Part A or B) or the Children's Health Insurance Program;
- dies;
- voluntarily withdraws; or
- moves out of Texas.

W-1940, Setting Special Reviews

Body

Revision 07-0; Effective July 1, 2007

Do not set a special review even if a known change is to occur during the woman's 12-month continuous eligibility period. Document the known change and use the information at the next renewal. Follow current procedures and report the known change if the applicant has other active Eligibility Determination Group cases.

W-1950, Adverse Action

Body

Revision 15-4; Effective October 1, 2015

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations, households may continue benefits pending an appeal. After certification, give households advance notice of adverse actions to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

For adverse action, use current policy in A-2340, Adverse Action.

W-2000, Processing Time Frames

W-2010, Applications

Body

Revision 21-3; Effective July 1, 2021

Make an eligibility determination by the 45th day from the file date.

Follow policy for medical programs when reopening an application denied for failing to furnish information or verification.

Follow policy for medical programs when reopening a renewal application denied for failing to furnish information or verification.

Related Policy

Reuse of an Application Form After Denial, B-111
Denied for Failure to Provide Information/Verification, B-122.3.2

W-2020, Deadlines

Body

Revision 21-3; Effective July 1, 2021

Provide Form TF0001, Notice of Case Action, the same day eligibility is determined for an application but no later than 45 days from the file date.

W-2030, Missed Appointments

Body

Revision 07-0; Effective July 1, 2007

No appointment is required to process an application or renewal unless requested by the applicant/individual. If requested, provide the applicant/individual a telephone interview. If she fails to keep the appointment, do not deny the application/renewal but continue to process.

W-2040, Pending Information on Applications

Body

Revision 15-4; Effective October 1, 2015

Advisors must request documents that are readily available to the household to be sufficient verification. Each handbook section lists potential verification sources. C-900,Verification and Documentation, gives information on verification procedures.

In determining eligibility, advisors must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

W-2050, Notice of Renewal/Expiration

Body

Revision 21-3; Effective July 1, 2021

The Texas Integrated Eligibility Redesign System (TIERS) generates HTW renewal correspondence automatically, following the procedures for other medical programs. Determine if a woman is eligible to continue to receive HTW benefits using the same eligibility requirements for an application.

If the woman states on her application that she has creditable health insurance that covers family planning services and that filing a claim will not cause her physical, emotional or other harm, deny the renewal using the third-party resource denial reason language.

Related Policy

Receipt of Application, A-121
Notice of Redetermination/Certification Expiration, B-121
Third-Party Resource, W-914

W-2060, Processing Renewals

Body

W—2061 How to Process a Renewal

Revision 21-3; Effective July 1, 2021

There is not an interview requirement for HTW renewals. Follow medical program administrative renewal policy to process HTW renewals.

Related Policy

Medical Program Administrative Renewals, B-122.4

W—2062 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 07-0; Effective July 1, 2007

Case Action	Due Date	Final Due Date
Application	10 days	• 30 days, or • 10th day if 10 days end after 30th day
Untimely renewal	10 days	• 30 days, or • 10th day if 10 days end after 30th day
Timely renewal	10 days	• last workday of last benefit month, or • 10th day if 10 days end after last benefit month
Incomplete review	10 days	• 10 days

Note: Staff have until the 45th day of the file date to determine eligibility.

W-2070, Renewal Time Frames

Body

Revision 21-3; Effective July 1, 2021

Use the medical program administrative renewal timeliness guidelines.

Related Policy

Medical Program Administrative Renewals, B-122.4

W-2080, Pending Information

Body

Revision 21-3; Effective July 1, 2021

If the applicant cannot furnish all required verification during the interview or with the application, allow the household at least 10 days to provide verification. The due date must be a workday. Determine what sources of verification are readily available to the household and request those first. If the applicant has an active or inactive EDG, check to see if any verification previously provided on another EDG can be used to determine eligibility for HTW.

HTW uses reasonable compatibility to verify household income.

Note: Do not use verification that is more than 60 days older than the HTW file date.

Use verification accepted for Temporary Assistance for Needy Families (TANF), Medical Programs or the Supplemental Nutrition Assistance Program (SNAP) for HTW. **Exception**: Verification of U.S. citizenship for applicants must be from a Medicaid acceptable source.

To ensure their confidentiality, women have an opportunity to provide a different mailing address and contact phone number on their application and renewal form. Since HTW provides family planning services, it is imperative to respect the privacy of HTW applicants and recipients.

Related Policy

Verification Requirements, A-1370
Confidentiality, W-2400

W-2100, Changes

W-2110, How to Report a Change

Body

Revision 21-3; Effective July 1, 2021

Women enrolled in Healthy Texas Women (HTW) can report changes:

- via YourTexasBenefits.com;
- via Your Texas Benefits mobile app;
- by calling or visiting a local Texas Health and Human Services Commission (HHSC) benefits office;
- in writing, by mail or fax;
- by completing Form H1019, Report of Change, and mailing or faxing the form to a local HHSC benefits office; or
- by calling 2-1-1.

Note: When a change is reported by calling 2-1-1, verify that the person speaking has the authority to report a change.

A woman is continuously eligible for HTW for 12 months or through the month of her 45th birthday, whichever is earlier.

HTW recipients are required to report the following changes:

- a person's change of address;
- death;
- pregnancy;
- receipt of creditable health coverage; or
- moves out of Texas.

Process required changes, except for receipt of creditable health coverage, following medical programs change policy.

Note: Update the case information for all reported changes regardless of whether the recipient is required to report the change.

Exception: If the person failed to report required information at the time of the application that causes the person to be ineligible for HTW, deny the case.

Related Policy

Changes, B-600
Pregnant Women, W-912

W—2111 Changes Received by Phone

Revision 21-3; Effective July 1, 2021

When a person reports a change by phone for a case that includes an HTW Eligibility Determination Group (EDG), verify that the person reporting the change is one of the following before discussing any information regarding the HTW EDG:

- the HTW applicant or recipient;
- the woman's authorized representative; or
- the parent or legal guardian of HTW minor recipients.

If the person has the authority to report a change for the HTW EDG, ask them which EDGs the change pertains to – all EDGs including HTW, all EDGs excluding HTW or only the HTW EDG, and take the appropriate action.

If the person does not have authority to report a change for the HTW EDG, **do not** discuss the HTW EDG information with this person; only discuss the information regarding the other EDGs.

If the change is a mailing address change for **only** the HTW EDG, enter the mailing or confidential address into the Issuance Address page for the HTW EDG. **Do not** enter the new mailing address in the Address page, as this will change the Case Level Address for all other EDGs.

Related Policy

Authorized Representative, A-170

W—2112 Changes Received via Mail

Revision 19-1; Effective January 1, 2019

When a person reports a change by mail and there is an HTW EDG in the case, staff must determine if the change pertains to all EDGs including HTW, all EDGs excluding HTW, or only the HTW EDG.

If the written change:

- does not specifically state that the mailing address change is for the HTW EDG, only take action on the appropriate EDGs, excluding the HTW EDG;
- specifically states the change is for only the HTW EDG, only make changes to the HTW EDG and no other EDGs; or
- specifically states the change is for all EDGs including the HTW, take action on all EDGs as stated by the HTW recipient.

Note: The written report of change must specifically state the name of the person reporting the change to process an HTW change. Compare the name provided to the HTW recipient, or parent or legal guardian for HTW minors. If this person is not the HTW recipient or parent or legal guardian, do not change the mailing or confidential address for the HTW EDG.

W—2113 Changes Received at a Local HHSC Benefits Office

Revision 17-2; Effective April 1, 2017

If an individual visits a local eligibility office, staff must determine the person is the HTW applicant/recipient or parent/legal guardian of an HTW minor.

If the individual is the HTW applicant/recipient or parent/legal guardian, ask the individual which EDGs the change pertains to – all EDGs including HTW, all EDGs excluding HTW or only HTW, and take the appropriate action.

If the individual is not the HTW applicant/recipient or parent/legal guardian, **do not** discuss the HTW EDG information with this person; only discuss the information regarding the other EDGs.

W-2120, Action on Changes

Body

Revision 15-4; Effective October 1, 2015

If an individual reports a change or the advisor receives an agency-generated change during the 12-month continuous eligibility period and has:

- **No associated EDG**, document the change and handle at renewal, unless it is a change of address, the certified woman dies, a voluntary withdrawal, or the individual moves out of Texas.
- **An associated EDG**, document the change and handle at renewal unless it is a change of address, the certified woman dies, a voluntary withdrawal, or the individual moves out of Texas. Process the change for an associated EDG using current process.
- **A change of address**, mail the individual form VR30, Texas Voter Registration Application, to register to vote based on the new address. If the individual contacts the local eligibility office or 2-1-1 to decline the opportunity to register to vote after receipt of form VR30, mail Form H1350, Opportunity to Register to Vote, to the individual for a signature. File Form H1350 in the case record when the individual returns the form and retain the form for at least 22 months.

Related Policy

Registering to Vote, A-1521

W-2130, Determining Whether New Income Information Is a Reported Change

Body

Revision 17-2; Effective April 1, 2017

When an advisor processes a HTW application/renewal during a Temporary Assistance for Needy Families (TANF)/Medicaid/Supplemental Nutrition Assistance Program (SNAP) certification period and a household member's source of income currently budgeted on another active EDG has not changed, the advisor must determine whether the member is reporting a change in income. To do this, the advisor determines if the income verification the applicant provided with the HTW application/renewal is:

- a more recent payment than previously verified; and
- within the range of payments previously verified that are currently used in the budget for the associated active case(s), whether the individual provides only one or more than one payment.

If a change is reported during the HTW application/renewal, the advisor processing the HTW EDG must take action on the associated TANF/Medicaid/SNAP EDG. The file date is considered the report date for purposes of determining the effective date of the change. The date the advisor works the HTW EDG and becomes aware of the change is day zero for purposes of taking action on the change for the associated EDG. The individual must provide any requested verification by the due date on Form H1020, Request for Information or Action, to be considered timely verification.

For more information, see policy in B-623.1, Determining Whether New Income Information Is a Reported Change.

W-2200, Fair Hearings

Body

W-2210, Appeals Procedures

Body

Revision 21-3; Effective July 1, 2021

Healthy Texas Women (HTW) follows the appeals policy for medical programs.

Related Policy

Fair Hearings, B-1000

W-2300, Automated Support

W-2310, Data Broker

Body

Revision 15-4; Effective October 1, 2015

Advisors must follow the policy explained in C-817, Electronic Data Sources (ELDS), and C-820, Data Broker.

W-2400, Confidentiality

Body

Revision 21-3; Effective July 1, 2021

The Texas Health and Human Services Commission (HHSC) must accommodate reasonable requests to receive communications by alternative means or at alternate locations.

The person must specify in writing the alternate mailing address or means of contact. They must include a statement that using the home mailing address or normal means of contact could endanger them. Medicaid applications and renewal forms and the forms listed below allow women to provide a confidential mailing address and phone number for their Healthy Texas Women (HTW) Eligibility Determination Group (EDG):

- Form H1871, HTW Client Turing 18 Years Old; and
- Form H1872, HTW Opting Out and Reporting Confidential Address.

Do not provide any information regarding Healthy Texas Women (HTW) to anyone other than the certified household member, the authorized representative (AR) of an HTW certified woman, or the parent or legal guardian of an HTW minor.

Related Policy

Authorized Representatives (AR), A-170

W-2410, Applications

Body

Revision 21-3; Effective July 1, 2021

If there is a current **mailing address** in the Texas Integrated Eligibility Redesign System (TIERS), determine if it is the same as the mailing or confidential address on the woman's application.

If ...	then ...
the current mailing address is different from the address provided on the HTW application **or** no case information exists in TIERS	enter the mailing or confidential address provided on the HTW application in the **Issuance Address LUW** for the HTW EDG.
the current mailing address is the same as the address provided on the HTW application	no action is required.

If the **physical address** is different on the application than what is verified in TIERS, report the new address using current change processes for the other EDGs.

Related Policy

Changes, B-600
How to Report a Change, W-2110

W-2420 Renewals

Body

Revision 21-3; Effective July 1, 2021

TIERS mails out the HTW renewal application in the 9th month of the 12-month certification period. TIERS uses the Form TF0001, Notice of Case Action, address hierarchy when mailing this correspondence.

Determine if the HTW recipient has provided a new mailing or confidential address for the HTW EDG on their HTW renewal application. Perform an inquiry in the Issuance Address page to determine if the mailing or confidential address has changed or was not entered.

Determine if the person has a different mailing address for the HTW renewal than their other EDGs.

If the mailing or confidential address:

- is different from their other EDGs, then enter the mailing or confidential address into the Issuance Address page for the HTW EDG;
- is different from the Issuance Address page, enter the new mailing or confidential address into the Issuance Address page for the HTW EDG;
- was never provided, enter the mailing or confidential address into the Issuance Address page; and
- is the same as the current mailing address for the other EDGs, no action is required.

If the **physical address** is different on the HTW renewal packet than what is verified in TIERS, report the new address using current change processes for the other EDGs.

Related Policy

Medical Program Administrative Renewals, B-122.4
Changes, B-600
How to Report a Change, W-2110

W-2430, Telephone Numbers

Body

Revision 17-2; Effective April 1, 2017

Staff must determine if the telephone number provided by the HTW applicant is different than what was provided for the other EDGs.

If the telephone number is different, document the following in the case comments:

Use (insert telephone number) when contacting the individual regarding HTW EDG information.

W-2440, Creating Separate Cases

Body

Revision 21-3; Effective July 1, 2021

Determine if a new case is needed when a woman is tested for HTW eligibility.

If the applicant …	and …	then …
does not have an existing HTW EDG,	she or her spouse (or non-spouse with mutual children in the budget group) is the case name on an existing case,	associate her application with that case.
does not have an existing HTW EDG,	she is included in an EDG in someone else's case such as her mother, father, non-spouse with no mutual children, etc.,	create a new case for her and associate the application with the new case.

Part X, Medicaid for Breast and Cervical Cancer

X-100, Application Processing

Body

X–110 Medicaid for Breast and Cervical Cancer (MBCC)

Revision 15-4; Effective October 1, 2015

The Breast and Cervical Cancer Control Program and Treatment Act of 2000 gives states the authority to provide Medicaid to low-income women previously not eligible under the Medicaid program. The Centers for Medicare and Medicaid Services approved a state plan amendment to allow Texas to provide full Medicaid benefits to uninsured women under age 65 who are identified through the Texas Department of State Health Services (DSHS) Breast and Cervical Cancer Services (BCCS) programs and who are in need of treatment for breast or cervical cancer, including pre-cancerous conditions. The program was implemented September 1, 2002.

The 80th Texas Legislature, Regular Session, 2007, provided funding to expand the pool of providers who provide screening and diagnostic services to women. As of September 1, 2007, any provider can diagnose a woman for breast or cervical cancer so that she may be eligible for Medicaid through MBCC.

MBCC is displayed in the Texas Integrated Eligibility and Redesign System (TIERS) as TA 67, MA-MBCC.

X–111 MBCC-Presumptive

Revision 12-3; Effective July 1, 2012

Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid for a limited period of time based on a determination by a Medicaid provider of likely Medicaid eligibility. Texas chose the presumptive eligibility option offered in the Breast and Cervical Cancer Control Program and Treatment Act of 2000. The option facilitates prompt Medicaid enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer.

BCCS contractors determine a woman's presumptive eligibility for MBCC and indicates this on Form H1034, Medicaid for Breast and Cervical Cancer. Specialized staff at Centralized Benefit Services (CBS) certify the woman for MBCC-Presumptive if additional information or verification is needed to determine eligibility for another type of Medicaid or ongoing MBCC.

MBCC-Presumptive is displayed in TIERS as TA 66, MA – MBCC-Presumptive.

X–120 General Overview

Revision 17-1; Effective January 1, 2017

To qualify for MBCC, an applicant must:

- be a woman under age 65;
- have been screened for breast or cervical cancer and found to need treatment for either breast or cervical cancer;

- not be insured, that is, she must not otherwise have creditable coverage (creditable coverage refers to a health plan that covers treatment for breast and cervical cancer as well as current enrollment in Medicaid, Medicare or the Children's Health Insurance Program [CHIP]);
- meet Medical Programs citizenship and identity requirements;
- not be eligible for another type of medical assistance; and
- be a resident of Texas.

Only specified staff at CBS determines eligibility for MBCC-Presumptive and MBCC.

If a woman returns the requested information or verification and meets Medicaid eligibility requirements for another type of Medicaid or MBCC, her MBCC-Presumptive Eligibility Determination Group (EDG) is denied prospectively and she is certified for the other type of Medicaid or MBCC. If the woman fails to return the requested information or if based on the information provided, she does not meet Medicaid eligibility requirements, her MBCC-Presumptive EDG is denied effective the date she is found ineligible for ongoing Medicaid.

Once determined eligible for MBCC, a woman remains eligible for Medicaid through the duration of her cancer treatment or until she no longer meets the eligibility criteria, whichever is earlier.

If field staff receives inquiries regarding this program, refer the woman to 2-1-1. Staff at 2-1-1 can assist the woman in locating a Breast and Cervical Cancer Services (BCCS) contractor near their residence who can determine if they have a qualifying diagnosis for MBCC and, if so, assist the woman in applying for MBCC.

X–130 Application Processing

X–131 Application Procedures

Revision 17-3; Effective July 1, 2017

New applicants apply for MBCC using Form H1034, Medicaid for Breast and Cervical Cancer. New applicants cannot apply for MBCC using any other application.

Form H1034 can only be obtained through a contracted BCCS provider.

A woman can locate a contracted BCCS provider in her area at healthytexaswomen.org/find-a-doctor.

The BCCS provider assists the individual in completing the application.

A former MBCC recipient can reapply for MBCC, without going through a BCCS provider to be screened, using Form H2340, Medicaid for Breast and Cervical Cancer Renewal, and Form H1551, Treatment Verification, if it has been 12 months or less since the diagnosis date for breast or cervical cancer or the date her active treatment was last verified, whichever is later.

X–132 MBCC Forms

Revision 15-4; Effective October 1, 2015

Medicaid for Breast and Cervical Cancer uses the following specialized forms:

- Form H1034, Medicaid for Breast and Cervical Cancer
- Form H2340, Medicaid for Breast and Cervical Cancer Renewal
- Form H2340-OS, Medicaid for Breast and Cervical Cancer
- Form H1550, Out of State NBCCEDP Verification
- Form H1551, Treatment Verification

X–133 Women's Health Services (WHS) Procedures

Revision 16-3; Effective July 1, 2016

Form H1034, Medicaid for Breast and Cervical Cancer, is faxed by a contracted provider to HHSC's WHS unit. The WHS contact validates Form H1034 as having been received and completed by a contracted BCCS provider and indicates if the individual has a qualifying medical diagnosis. Once validated, WHS faxes the application to the vendor. Providers are not allowed to fax Form H1034 directly to the vendor or the HHSC eligibility staff.

Note: Do not process an application if it is not received from WHS without contacting WHS to determine if it is a valid MBCC application.

X–134 File Date

Revision 20-4; Effective October 1, 2020

The file date is the date the BCCS contractor determines the woman is presumptively eligible for MBCC. The contractor enters this date in Section 3 of the BCCS Contractor Certification page on Form H1034, Medicaid for Breast and Cervical Cancer. If the application is not forwarded to the HHSC vendor within five business days from the presumptive eligibility date, the file date is the date HHSC receives the application.

Document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on Form H1034; or
- Form H1034 has two received dates.

X–135 Interviews

Revision 10-2; Effective April 1, 2010

An interview is not required when applying for or renewing an application for the MBCC. Schedule a phone interview only if the individual requests an interview.

Note: Do not deny the application if the applicant misses her interview; continue determining eligibility.

X–136 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

An individual may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

X-200, Household Composition

Body

X—210 General Policy

Revision 15-4; Effective October 1, 2015

Only the Medicaid for Breast and Cervical Cancer (MBCC) applicant is included in the budget and certified groups for MBCC-Presumptive and MBCC.

X-300, Citizenship

Body

X–310, General Policy

Revision 12-3; Effective July 1, 2012

Medicaid for Breast and Cervical Cancer (MBCC) follows the Medical Programs citizenship policy in A-300, Citizenship.

Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for MBCC if they meet all other eligibility criteria.

Note: MBCC-Presumptive or MBCC recipients who are qualified immigrant or non-immigrant who meet the eligibility criteria in A-342, TANF and Medical Programs Alien Status Eligibility Charts, Chart D, who applied before their 19th birthday, remain eligible for MBCC through the duration of their cancer treatment or until they no longer meet all the other eligibility criteria, whichever is earlier.

X-310, General Policy

Body

Revision 12-3; Effective July 1, 2012

Medicaid for Breast and Cervical Cancer (MBCC) follows the Medical Programs citizenship policy in A-300, Citizenship.

Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for MBCC if they meet all other eligibility criteria.

Note: MBCC-Presumptive or MBCC recipients who are qualified immigrant or non-immigrant who meet the eligibility criteria in A-342, TANF and Medical Programs Alien Status Eligibility Charts, Chart D, who applied before their 19th birthday, remain eligible for MBCC through the duration of their cancer treatment or until they no longer meet all the other eligibility criteria, whichever is earlier.

X-400, Social Security Number

Body

X-410, General Policy

Revision 20-2; Effective April 1, 2020

All applicants must provide a Social Security number (SSN) or apply for one through the Social Security Administration.

If the woman applies using Form H1034, Medicaid for Breast and Cervical Cancer, and does not provide an SSN or proof that she has applied for one, certify for Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive while awaiting the information.

If the woman applies using Form H2340-OS, Medicaid for Breast and Cervical Cancer, and does not provide an SSN, send Form H1020, Request for Information or Action, to request the SSN or proof of an application for an SSN. If the information is not provided, do not certify for MBCC unless good cause for not providing an SSN is applicable as outlined in A-410, General Policy.

MBCC follows the SSN policy in A-400, Social Security Number, under the All Programs or Medical Programs headings.

X-500, Age

Body

X—510 General Policy

Revision 15-4; Effective October 1, 2015

A woman is eligible to receive Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC through the month of her 65th birthday. She becomes ineligible the month after her 65th birthday.

Note: The Texas Integrated Eligibility Redesign System (TIERS) automatically denies an MBCC-Presumptive or MBCC Eligibility Determination Group (EDG) at the end of the month in which the MBCC recipient turns age 65 and generates Form TF0001, Notice of Case Action, notifying the woman of the denial.

X—520 Verification Requirements

Revision 10-2; Effective April 1, 2010

Accept self-declaration as verification of age.

X—530 Documentation Requirements

Revision 10-2; Effective April 1, 2010

Document the individual's self-declaration establishing her age.

X-600, Relationship

Body

Revision 12-3; Effective July 1, 2012

Relationship does not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

X-700, Identity

X-710, General Policy

Body

Revision 12-3; Effective July 1, 2012

To establish identity, follow policy for Medical Programs in A-600, Identity.

X-800, Residence

X-810, General Policy

Body

Revision 15-4; Effective October 1, 2015

Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive and MBCC follow Children's Medicaid (TP 33, TP 34, TP 35, TP 43, TP 44, TP 45 and TP 48) policy in A-700, Residence.

X-900, Medicaid Eligibility

X-910, Screening and Active Treatment

Body

Revision 12-3; Effective July 1, 2012

To qualify for Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC, applicants must have been screened and found to need active treatment for either breast or cervical cancer.

Related Policy

Screening, X-911

At each periodic review, MBCC recipients must provide verification that they continue to receive treatment for breast or cervical cancer.

Related Policy

Active Treatment, X-912

X—911 Screening

Revision 15-4; Effective October 1, 2015

A woman must be screened for breast and cervical cancer under the Centers for Disease Control and Prevention's (CDC's) National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The Breast and Cervical Cancer Services (BCCS) contractor or provider, through the Texas Department of State Health Services (DSHS), is responsible for providing the Texas Health and Human Services Commission (HHSC) with verification that a woman has been screened and diagnosed using the NBCCEDP criteria.

A woman is considered screened under the NBCCEDP if:

- CDC Title XV funds paid for all or part of the cost of her screening services; or
- her particular clinical service has not been paid for by CDC NBCCEDP Title XV funds, but the:
  - service was provided by a provider and/or an entity funded at least in part by CDC Title XV funds;
  - service was within the scope of a grant, sub-grant or contract under that state program; and
  - state CDC Title XV grantee has elected to include such screening activities provided by the provider as screening activities pursuant to CDC Title XV.

The 80th Texas Legislature passed Senate Bill 10, the Medicaid Reform Act, which authorized any health care provider to refer eligible women in need of treatment for breast or cervical cancer to Medicaid. Beginning September 1, 2007, any woman diagnosed with breast or cervical cancer may receive MBCC if they meet all eligibility requirements. The diagnosing provider refers the woman to a BCCS contractor who assists the woman in applying for MBCC.

If Form H1034, Medicaid for Breast and Cervical Cancer, is received and the woman does not have a qualifying medical diagnosis, deny the application due to the woman not having a diagnosis for breast or cervical cancer.

X—912 Active Treatment

Revision 15-4; Effective October 1, 2015

At reapplication and at each redetermination, the MBCC applicant or recipient must provide Form H1551, Treatment Verification, completed by her treating health professional verifying that she needs active treatment services for breast or cervical cancer. Active cancer treatment includes services related to the individual's condition as documented in her plan of care, such as:

- surgery,
- chemotherapy,
- radiation,
- reconstructive surgery, and
- medication (ongoing hormonal treatment).

These services also may include diagnostic services that are necessary to determine the extent and proper course of treatment and active disease surveillance for triple negative receptor breast cancer.

Women who are determined to require only routine health screening services for a breast or cervical condition (for example, annual clinical breast examinations, mammograms and pap tests as recommended by the American Cancer Society and the U.S. Preventative Services Task Force) are not considered to need treatment and are not eligible for MBCC. A woman may reapply for MBCC if she is later diagnosed with a new breast or cervical cancer, pre-cancerous condition or a metastatic or recurrent breast or cervical cancer.

If the woman's treating health professional indicates on Form H1551 that she is not actively receiving treatment, deny the MBCC Eligibility Determination Group (EDG) due to the woman not actively receiving treatment.

X-920, Medicaid Coverage

Body

Revision 22-3; Effective July 1, 2022

Women who are eligible for MBCC-Presumptive or MBCC receive full regular Medicaid benefits.

Before certifying a woman for MBCC-Presumptive or MBCC, Centralized Benefit Services (CBS) staff complete inquiry into the Texas Integrated Eligibility Redesign System (TIERS) to determine if the applicant currently receives Medicaid or Children's Health Insurance Program (CHIP) benefits. Deny the MBCC application if the woman receives other Medicaid coverage.

Exceptions: Do not deny the application if the woman's Medicaid coverage is ending.

Note: If a woman certified for Healthy Texas Women (HTW) becomes eligible for MBCC, there may be an overlap in coverage for the month in which she applies for MBCC. MBCC eligibility begins the date an applicant meets all eligibility criteria and cannot precede the day after the diagnosis date. After the woman is determined eligible for MBCC, terminate HTW prospectively.

Related Policy

Medicaid Effective Date (MED), X-921
Other Medical Assistance, X-932
Current Medicaid, Medicare (Part A or B) and Children's Health Insurance Program (CHIP) Recipients, W-911

X—921 Medical Effective Date (MED)

Revision 12-3; Effective July 1, 2012

Medicaid eligibility begins the date an applicant meets all eligibility criteria. The MED cannot precede the day after the diagnosis date.

For MBCC-Presumptive, the MED is the date the BCCS contractor determines the woman is presumptively eligible for MBCC, but no earlier than the date after the woman was diagnosed with breast or cervical cancer. If the woman provides information needed for MBCC eligibility, provide MBCC coverage for dates that precede the MBCC-Presumptive MED.

Related Policy

Prior Coverage, X-922

X—922 Prior Coverage

Revision 15-4; Effective October 1, 2015

A woman may be eligible for up to three months of prior coverage under MBCC if all other eligibility requirements are met. MBCC only covers unpaid medical bills for services received after the individual's breast and cervical cancer diagnosis date. If a woman indicates on Form H1034, Medicaid for Breast and Cervical Cancer, that she has unpaid medical bills that occurred during the three months before she applied for MBCC, assign an MED of the day after her diagnosis date. Do not require the woman to provide proof of the unpaid medical bills or a completed Form H1113, Application for Prior Medicaid Coverage.

For medical expenses incurred before or on her date of diagnosis, the client must apply for prior Medicaid coverage using Form H1010, Texas Works Application for Assistance — Your Texas Benefits; Form H1205, Texas Streamlined Application; or online at YourTexasBenefits.com. Refer the client to an HHSC eligibility office for the appropriate application or have the client call 2-1-1 to locate the nearest HHSC eligibility office.

Example One: The applicant was diagnosed on August 15 and applied for MBCC on November 21 indicating that she has unpaid medical bills for August, September, October and November. Assign an MED of August 16.

Example Two: The applicant was diagnosed on July 7 and applied for MBCC on July 21 indicating that she has unpaid medical bills for May and June. The individual is not eligible for prior coverage under MBCC since the unpaid medical bills were before her diagnosis date. Assign an MED of July 8.

Example Three: The applicant was diagnosed on January 31 and applied for MBCC on June 4 indicating she has unpaid bills for February. The woman is not eligible for prior coverage since her unpaid medical bills occurred prior to the three-month period before she applied for MBCC.

Note: If the applicant had creditable coverage before applying for MBCC and indicates she has unpaid medical bills for the months she was covered by insurance, the client is not eligible for prior coverage under MBCC. The client must apply for prior Medicaid coverage using Form H1010, Form H1205, or online at YourTexasBenefits.com to determine whether she meets all eligibility requirements for prior Medicaid. See A-831, Three Months Prior Coverage.

X—923 Medicaid Termination

Revision 20-4; Effective October 1, 2020

MBCC eligibility ends when the recipient first meets any of the following conditions. The recipient:

- becomes 65;
- obtains creditable coverage;
- is no longer receiving active treatment for breast or cervical cancer;
- no longer resides in Texas;
- is confined in a public institution; or
- dies.

Related Policy

Termination of Medical Coverage for People Confined in a Public Institution, B-510

X—924 Types of Coverage

Revision 18-1; Effective January 1, 2018

People certified for MBCC-Presumptive receive their medical care via fee-for-service.

People certified for MBCC are enrolled in the STAR+PLUS managed care program.

Related Policy

Managed Care, A-821.2
Managed Care Plans, C-1116

X-930, Creditable Coverage

Body

X-931 General Overview

Revision 17-2; Effective April 1, 2017

A woman is ineligible to receive MBCC if she has creditable coverage. Deny an MBCC application if her plan covers breast or cervical cancer treatment.

Creditable coverage is defined as:

- group health insurance;
- health insurance coverage;
- Medicare (Part A or B);
- Medicaid;
- CHIP;
- armed forces insurance; or
- a state health risk pool.

Do not consider a plan with a limited scope of coverage such as dental, vision, long-term care, etc., or for only a specific illness/disease, such as drug/substance abuse, as creditable coverage. **Note:** Healthy Texas Women (TA 41) is not considered creditable coverage.

Consider a woman as having creditable coverage even if it has limits on benefits, such as limited drug coverage or limits on the number of outpatient visits, or high deductibles. A woman is considered to no longer have creditable coverage if she:

- is in a period of exclusion (such as pre-existing condition exclusions or a health maintenance organization [HMO] affiliation period) for treatment of breast or cervical cancer; or
- exhausts her lifetime limit on all benefits under the plan or coverage or her yearly benefits for breast or cervical cancer treatment. When the new plan year begins, determine if the woman has creditable coverage.

Note: Set a special review if it is known that the exclusion period of the creditable coverage will expire (pre-existing period has expired) or the woman's yearly benefits for breast or cervical cancer treatment will be reinstated before the next periodic review. See X-1930, Setting Special Reviews.

Women screened under BCCS are not subject to a waiting period if they had prior creditable coverage.

As long as the termination of the creditable coverage occurs before disposition, a woman is eligible to receive benefits under the MBCC program.

A woman is required to report when she has obtained creditable coverage.

If an MBCC applicant indicates she has health insurance but does not know whether it provides coverage for breast or cervical cancer, certify the woman for MBCC-Presumptive. Contact the insurance provider to verify whether the policy provides coverage for breast or cervical cancer.

X-932 Other Medical Assistance

Revision 25-1; Effective Jan. 1, 2025

An MBCC applicant is not eligible to receive benefits if she is currently receiving Medicaid, Medicare Part A or B, or coverage through CHIP. If an application is received for a woman who receives Medicaid, Medicare Part A or B or CHIP, or if a Medicaid or CHIP application is certified before the MBCC application, deny the MBCC application.

Exception: If an MBCC application is received for a woman certified on Medicaid for Pregnant Women (TP 40), certify the woman for MBCC, if eligible. If the woman becomes ineligible for MBCC during her pregnancy or postpartum period, the woman is transitioned to TP 40 until the end of her 12-month postpartum period.

Staff must verify via TIERS, the State Online Query (SOLQ) or the Wire Third-Party Query (WTPY) system that an applicant is not currently enrolled in Medicaid, Medicare Part A or B, CHIP, or Healthy Texas Women (HTW) before disposition. If a woman is eligible for MBCC and is currently receiving HTW, the HTW EDG must be denied.

X-932.1 Currently Receiving MBCC and Applies for Other Benefits

Revision 25-1; Effective Jan. 1, 2025

A woman receiving MBCC-Presumptive or MBCC who is found eligible for another type of Medicaid program is ineligible to continue to receive MBCC-Presumptive or MBCC. MBCC staff receive a task to prospectively deny the MBCC-Presumptive or MBCC EDG so that the

staff processing the application can certify the woman for the other type of Medicaid. The MED for the other Medicaid type begins the first of the month following the MBCC-Presumptive or MBCC EDG denial.

Exception: A woman certified for MBCC who reports a pregnancy remains on MBCC. Do not transition the woman to TP 40.

When the other Medicaid type of assistance is denied, the woman may be eligible for MBCC if she continues to need active treatment for breast or cervical cancer and she meets all other eligibility criteria. When the non-MBCC Medicaid is denied for reasons other than death, unable to locate or a move out of state, the eligibility determination system generates a reapplication packet if the woman is under 65 and less than 12 months has passed since her diagnosis date or the date her active treatment was last verified, whichever is later. The reapplication packet contains:

- Form H1833, Your Medicaid Benefits Are Ending - Cover Letter; or
- Form H1834, Your Medicaid Benefits Have Ended - Cover Letter;
- Form H2340, Medicaid for Breast and Cervical Cancer Renewal;
- Form H1551, Treatment Verification;
- a self-addressed envelope; and
- form VR30, Texas Voter Registration Application.

The woman must return the completed Form H2340 and Form H1551 for her eligibility for MBCC to be reconsidered.

If more than 12 months have passed since the woman's diagnosis date or her active treatment was last verified, the woman must be screened and reapply for MBCC through a Breast or Cervical Cancer Services (BCCS) contractor using Form H1034, Medicaid for Breast and Cervical Cancer. The eligibility determination system generates either Form H1833-L, Your Medicaid Benefits Are Ending, or Form H1834-L, Your Medicaid Benefits Have Ended, informing the woman how to reapply for MBCC and providing the Healthy Texas Women web address where the woman can locate a BCCS contractor in her area.

X-940, New State Residents

Body

Revision 13-4; Effective October 1, 2013

If a woman is screened in another state through the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and moves to Texas, she may be eligible for MBCC in Texas. If a woman meets the MBCC eligibility criteria in Texas, her screening in another state does not prohibit her from receiving MBCC in Texas.

A new state resident requests MBCC in Texas by contacting 2-1-1. Form H2340-OS, Medicaid for Breast and Cervical Cancer, is mailed to the woman for her to complete and return.

Upon receipt of Form H2340-OS, CBS determines the woman's eligibility for MBCC. Staff must verify with the losing state the woman's screening under NBCCEDP and termination of any Medicaid benefits received in that state, if any, before certification. Use Form H1550, Out of State NBCCEDP Verification, to verify the applicants screening and diagnosis.

Related Policy

New Texas Residents, A-720
Medicaid Coverage for New State Residents, A-822

X-1000, Domicile

Body

Revision 15-4; Effective October 1, 2015

Domicile requirements do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

X-1100, Deprivation

Body

Revision 12-3; Effective July 1, 2012

Deprivation does not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

X-1200, Child Support

Body

Revision 12-3; Effective July 1, 2012

Child and medical support requirements do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

X-1300, Resources

X-1310, General Policy

Body

Revision 12-3; Effective July 1, 2012

Resources do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

X-1400, Income

Body

Revision 15-4; Effective Oct. 1, 2015

X–1410 General Policy

Revision 15-4; Effective Oct. 1, 2015

The Texas Health and Human Services Commission does not test for financial eligibility for Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

The woman must meet the financial eligibility criteria for the Breast and Cervical Cancer Services (BCCS) program to be eligible for MBCC-Presumptive or MBCC. This financial eligibility criteria is household income at or below 200 percent of the federal poverty income limit. The BCCS contractor verifies the woman's financial eligibility for the BCCS program before referring a woman to MBCC.

X-1410, General Policy

Body

Revision 15-4; Effective October 1, 2015

The Texas Health and Human Services Commission does not test for financial eligibility for Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

The woman must meet the financial eligibility criteria for the Breast and Cervical Cancer Services (BCCS) program to be eligible for MBCC-Presumptive or MBCC. This financial eligibility criteria is household income at or below 200 percent of the federal poverty income limit. The BCCS contractor verifies the woman's financial eligibility for the BCCS program before referring a woman to MBCC.

X-1500, Deductions

Body

Revision 12-3; Effective July 1, 2012

Deductions do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

X-1600, School Attendance

Body

Revision 12-3; Effective July 1, 2012

School attendance requirements do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

X-1700, Management

Body

Revision 15-4; Effective October 1, 2015

Management requirements do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

X-1800, Reminders

X-1810, General Policy

Body

Revision 15-4; Effective October 1, 2015

Before certifying applicants and processing reviews, complete the following:

- Ensure the applicant completes each item and signs and dates Form H1034, Medicaid for Breast and Cervical Cancer, the application for assistance.
- During processing, note if the applicant indicates changes on Form H1034 or during the interview, if an interview is requested. Document the nature of the change and when the individual expects the change to occur. If other programs exist for the individual, report the change to the appropriate office.
- Give or mail the applicant Form H1019, Report of Change. Explain that she must report changes involving her address or creditable coverage within 10 days after knowing about the change. Indicate the appropriate reporting requirement on Page 1.
- Refer the applicant to other programs for which she might be eligible such as Family Planning; Supplemental Security Income or other benefits from the Social Security Administration; and Women, Infants and Children (WIC). Refer aged and individuals with disabilities who are ineligible for Medical Programs for children and families to the Texas Health and Human Services Commission's (HHSC's) Medicaid for the Elderly and People with Disabilities (MEPD) programs.
- Inform the applicant of her right to appeal any HHSC action that affects her eligibility.
- Inform the applicant that the information she provided is subject to verification by third parties.
- Instruct individuals to report any accident-related injuries requiring medical care or accident-related unsettled legal claims within 60 days.
- Mail form VR30, Texas Voter Registration Application, with all applications and renewals. If the individual contacts the local office to decline the opportunity to register based on receipt of form VR30, use Form H1350, Opportunity to Register to Vote, to acknowledge the declination. Mail Form H1350 to the individual for her signature and, upon receipt, file a copy in the case record.

X-1820, Documentation Requirements

Body

Revision 15-4; Effective October 1, 2015

Document that the application was mailed along with form VR30, Texas Voter Registration Application, and Form H1350, Opportunity to Register to Vote.

X-1900, Case Disposition

X-1910, Notice to Applicants

Body

Revision 15-4; Effective October 1, 2015

Case disposition is the result of processing a request for assistance. Advisors must produce a notice of eligibility status. At the end of the interview, if one was requested by the client, or once Form H1034, Medicaid for Breast and Cervical Cancer; Form H2340, Medicaid for Breast and Cervical Cancer Renewal; or Form H2340-OS, Medicaid for Breast and Cervical Cancer, has been processed, mail the client one of the following notices to inform the individual that the case is pended, certified, sustained or denied.

Form H1020, Request for Information or Action

Form H1020 informs the individual the:

- reason the case is pending;
- action the individual or advisor must take;
- date by which the individual or advisor must take action; and
- date the advisor must deny the application/case if the individual does not take action, if applicable.

If all required proof/verification is not available when processing the application, the advisor allows the household at least 10 days to provide it. The due date must be a workday. Advisors determine what sources of proof/verification are readily available to the household and request those sources first if the advisor expects them to be sufficient proof/verification. If the applicant has an active or inactive Eligibility Determination Group (EDG) in the Texas Integrated Eligibility Redesign System (TIERS), the advisor checks to see whether any proof/verification previously provided on any other EDG can be used to determine eligibility for Medicaid for Breast and Cervical Cancer (MBCC).

Note: Verification previously provided on another case/EDG is only acceptable if it was provided within the 90 days preceding the file date.

Form TF0001, Notice of Case Action

If eligible for MBCC-Presumptive or MBCC, Form TF0001 informs the client of:

- the date benefits begin,
- her right to appeal, and
- the address and phone number of free legal services available in the area.

If the woman is certified for MBCC-Presumptive, a separate Form H1020 is sent informing her of the additional information needed to determine her eligibility for MBCC.

If ineligible for MBCC-Presumptive or MBCC, Form TF0001 informs the client of:

- the date of denial,
- her right to appeal, and
- the address and phone number of free legal services available in the area.

X—1911 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 10-2; Effective April 1, 2010

Case Action	Due Date	Final Due Date
Application	10 days from the date issued	• 30 days, or • 10th day if 10 days end after 30th day
Renewal	10 days from the date issued	By cutoff of review month
Incomplete review	10 days from the date issued	10 days

X-1920, Length of Certification

Body

Revision 25-2; Effective April 1, 2025

MBCC EDGs do not have certification periods.

TIERS calculates a review date from the case action disposition date as follows:

- Applications – 11 months from the date of disposition.
- Renewals – 12 months from the date of disposition.

X-1930, Setting Special Reviews

Body

Revision 13-1; Effective January 1, 2013

When processing an application or renewal, set a special review if it is known that before the next periodic review the exclusion period of the creditable coverage will expire (pre-existing condition period has expired) or the woman's yearly benefits for breast or cervical cancer treatment will be reinstated.

X-1940, Adverse Action

Body

Revision 10-2; Effective April 1, 2010

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations, households may continue receiving benefits pending an appeal. After certification, give households advance notice of adverse action to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

For adverse action, use current policy found in A-2340, Adverse Action.

X-2000, Processing Time Frames

X-2010, Applications

Body

Revision 20-4; Effective October 1, 2020

Process the application within two business days of receipt, but no later than 15 business days from the application file date.

Re-open an application denied for failure to provide information or verification if the missing information is provided. Use the date all of the missing information was provided as the new file date. The original Form H1034, Medicaid for Breast and Cervical Cancer, is valid for up to 60 days. If the information on Form H1034 has changed or is more than 45 days old, the person and staff must update the form.

X-2020, Deadlines

Body

Revision 12-3; Effective July 1, 2012

Provide Form TF0001, Notice of Case Action, the same day eligibility is determined. Determine eligibility no later than 15 days from the file date.

X-2030, Missed Appointments

Body

Revision 12-3; Effective July 1, 2012

No appointment is required to process an application or renewal unless requested by the applicant or recipient. If requested, provide a telephone interview. If she fails to keep her appointment, do not deny the application or renewal; continue to process the application/renewal.

X-2040, Pending Information on Applications

Body

Revision 15-4; Effective October 1, 2015

Advisors may not request additional information or documentation from clients unless such information is not available electronically or the information obtained electronically is not consistent with the information provided by the client.

Advisors must request documents that are readily available to the household if the advisor anticipates them to be sufficient verification. Each *Texas Works Handbook* section lists potential verification sources. C-900, Verification and Documentation, provides information on verification procedures.

In determining eligibility, the advisor must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

Note: Verification previously provided on another Eligibility Determination Group (EDG) is only acceptable if it was provided within the 90 days preceding the file date.

X-2050, Notice of Renewal

Body

Revision 25-2; Effective April 1, 2025

Texas Integrated Eligibility Redesign System (TIERS) generates a renewal packet three months before the periodic review due date.

The recipient's renewal packet includes:

- Form H1830, Application, Review, Expiration, Appointment Notice;
- Form H2340, Medicaid for Breast and Cervical Cancer Renewal;
- Form H1551, Treatment Verification, to verify the recipient is actively receiving treatment for breast or cervical cancer; and
- a self-addressed stamped envelope.

X-2060, Processing Renewals

Body

Revision 15-4; Effective October 1, 2015

The file date is the date the Texas Health and Human Services Commission (HHSC) receives the renewal application. Process the renewal by mail or telephone.

Note: Send the individual Form H1020, Request for Information or Action, if the individual did not provide Form H1551, Treatment Verification, with Form H2340, Medicaid for Breast and Cervical Cancer Renewal.

A woman remains eligible for Medicaid for Breast and Cervical Cancer (MBCC) when it is verified that she:

- has not turned age 65;
- is actively receiving treatment, as defined in X-912, Active Treatment; and
- does not have creditable coverage as defined in X-930, Creditable Coverage.

Deny a recipient if it is verified that she has creditable coverage, is not actively receiving treatment or is age 65 or older.

X-2070, Processing Time Frames

Body

Revision 16-3; Effective July 1, 2016

Advisors must process periodic reviews before cutoff in the month:

- the review date falls, if the review is due on or before cutoff; or
- after the review date, if the review is due after cutoff.

If the household must provide verification to complete the review, allow the household at least 10 days to provide it.

Advisors must reopen a renewal form denied for failing to furnish information or verification if the missing information is provided by the 60th day from the file date. The date the missing information/verification was provided is the new file date.

The original Form H2340, Medicaid for Breast and Cervical Cancer Renewal, can be used until it is 60 days old, following the policy explained in B-111, Reuse of an Application Form After Denial.

Advisors must consider a Form H2340 received after the last day of the certification period as an application using application processing time frames in X-2010, Applications, if it is received 12 months or less after the woman's breast or cervical cancer diagnosis date or the date active treatment was last verified, whichever is later.

X-2100, Changes

X-2110, General Policy

Body

Revision 12-3; Effective July 1, 2012

Recipients must report the following changes:

- moving out of state,
- obtaining creditable coverage,
- turning age 65,
- discontinuing treatment, or
- death.

Note: If a change for a Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC recipient is received in an eligibility office:

- without verification, staff take the change and enter it into the **State Portal-Report A TIERS Change** portlet and the system automatically creates and routes the change task appropriately.
- with verification, staff must complete an MI/Change Routing cover sheet and fax it to the vendor at 1-877-236-4123. The system creates and routes the change task appropriately.

X-2120, Actions on Changes

Body

Revision 10-2; Effective April 1, 2010

Centralized Benefit Services staff follow change processing procedures and time frames in B-631, Actions on Changes, under All Programs.

X-2200, Fair Hearings

X-2210, Appeals Procedures

Body

Revision 12-3; Effective July 1, 2012

Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC applicants/recipients receiving a notice of adverse action are entitled to continued benefits if the recipient requests them and appeals the decision within the advance adverse action time frame.

All renewal denials must receive advance notice of adverse action.

Refer to B-1000, Fair Hearings, for specific appeals policy and procedures.

X-2300, Confidentiality

X-2310, General Policy

Body

Revision 12-3; Effective July 1, 2012

Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC follows policy in B-1200, Confidentiality, for confidentiality policy and procedures.

TWH Glossary

Body

Revision 25-4; Effective Oct. 1, 2025

A

Able Bodied Adult Without Dependents (ABAWD) — A SNAP recipient who is:

- 18 through 54 years old;
- physically and mentally able to work 20 hours per week; and
- in a household where all members are over 18.

The ABAWD age criteria begins the month after the person turns 18 and ends the month the person turns 55.

Absent Parent — A child's parent who is not living in the home.

Accessibility Date — The date benefits are deposited into an Electronic Benefit Transfer (EBT) account.

Account Transfer — The way an applicant's information moves between the Marketplace and the Texas Health and Human Services Commission (HHSC) when a person applies for health insurance or medical programs. The account transfer from the Marketplace to HHSC, and from HHSC to the Marketplace, includes the information the applicant submitted through the original application and from verifications performed by either the Marketplace or HHSC.

Active-Duty Military Member — A person currently serving in the U.S. Armed Forces or Reserves, National Guard, or the State Military Forces or Texas State Guard, including the Army, Marine Corps, Navy, Air Force or Coast Guard.

Activity Fee — An additional cost incurred by the household associated with a structured dependent care program. This can include a fee for an art class that is part of an adult day care program, equipment fees or an extra cost for participation in a field trip as part of a summer program.

Adequate Notice — A notice of adverse action that expires the same day it is sent.

Administrative Renewal — The method used to redetermine eligibility for most Medical Programs, including Medicaid for the Elderly and People with Disabilities (MEPD) and the Children's Health Insurance Program (CHIP). The automated process uses existing applicant information, electronic data source information and reasonable compatibility when income verification is required. This results in:

- an automated eligibility determination; or
- a request for more information from the applicant to manually process the redetermination.

Administrative Review — A desk review of the fair hearing record by a Texas Health and Human Services (HHS) attorney to determine if the hearing officer's decision is correct. A request for an administrative review must be submitted in writing within 30 calendar days from the date of the hearing officer's decision.

Administrative Terminal Application (ATA) — A software program accessible on one or more Texas Health and Human Services Commission (HHSC) desktop computers in each office. It is used to issue Electronic Benefit Transfer (EBT) cards and replacements. The ATA allows access to the EBT system and may also be used for inquiry on EBT-related information, expedited Supplemental Nutrition Assistance Program (SNAP) benefit authorization, and account transaction updates to the EBT database.

Advance Notice — A notice of adverse action that expires 13 calendar days after the date on the notice.

Advanced Authentication — Personal security questions generated by third-party software to perform authentication of a person's identity before granting the person an account through YourTexasBenefits.com with Case Visibility.

Advanced Nurse Practitioner — A registered nurse with more training and a certification in a specific area of medicine, such as certified nurse-midwives, clinical nurse specialists and pediatric nurse practitioners.

Advanced Premium Tax Credit (APTC) — The payment of a tax credit by the federal government, provided on an advanced basis or at tax filing time, to an eligible person enrolled in a qualified health plan (QHP) through the Marketplace.

Adverse Action — Any HHSC action resulting in denial, suspension, reduction or termination of assistance. The term also applies to decisions for protective and restricted payments.

Agriculturally Related Activities — Employment:

- on a farm or ranch performing field work about planting, cultivating or harvesting operations; or
- in canning, packing, ginning, seed conditioning or related research or processing operations.

Aid — A benefit, coverage or service in programs that HHSC administers.

Alert — A system or user-generated reminder that action needs to be taken on a case or a notification that an action has already taken place.

Alerts — A functional area on a navigation bar that allows eligibility staff to request alerts and view outstanding and processed alerts.

Alien Sponsor — A person who signed an affidavit of support (U.S. Citizenship and Immigration Services [USCIS] Form I-864 or I-864-A) on or after Dec. 19, 1997, agreeing to support an alien as a condition of the alien's entry into the U.S. **Note:** Not all aliens must get a sponsor before being admitted into the U.S.

Alimony — Payments received from a spouse or former spouse under a divorce or separation decree. It is also referred to as spousal support.

Alimony Paid — Payments to a spouse or former spouse under a divorce or separation decree. It is also referred to as spousal support paid.

Alternate Payee — A person who receives the benefits for the EDG when people on the EDG are unable or ineligible to receive them. Types of alternate payees include a court appointed guardian, EBT representative, Financial Management Information System (FMIS) payee, long-term care (LTC) payee, protective payee and representative payee.

Annualize — Averaging income over a 12-month period.

Annuity — A series of payments paid under a contract and made at regular intervals over more than one full year. Payments may be either:

- fixed, under which one receives a definite amount; or
- variable, which is not fixed.

A person may buy the contract along or with the help of an employer.

Annulment — A court order declaring a marriage invalid.

Appeal — A request for a fair hearing concerning an HHSC action. Appeals are logged and updated in the **Hearing** functional area on the navigation bar.

Application — A form that a person or household uses to apply for assistance. This includes the Form H1010, Texas Works Application for Assistance — Your Texas Benefits, or the Form H1205, Texas Streamlined Application.

Application Registration — The functional area where a person's application for assistance is recorded.

Application Visibility — Type of YourTexasBenefits.com account given to an applicant who has selected not to go through Advanced Authentication. People with Application Visibility accounts may only apply for benefits and view and modify applications created under their username.

Applied Income — The countable amount of income for TANF after allowing deductions for tax dependents, child support, alimony and people a legal parent is legally obligated to support.

Assets — All items of monetary value owned by a person.

Assignable — Time periods that are available to schedule appointments using the **Scheduling** functional area.

Asylee — A person granted asylum under Section 208 of the Immigration and Nationality Act (INA).

Authorization Code — A code that identifies a retailer as a Food and Nutrition Service (FNS)-participating store. The code is used to request permission to use the Lone Star Card in a transaction.

Authorized Representative (AR) — A person or organization designated by an applicant or recipient to take the following actions on the applicant's behalf:

- sign an application;
- complete and submit a renewal form;
- receive copies of the applicant's or recipient's notices in the preferred language selected on the application and other communications from the agency;
- designate a health plan; and
- act on behalf of the applicant or recipient in all other matters with the agency, such as reporting changes.

Automated Income Check Process — The first step in a periodic income check (PIC). During this step, information from electronic data sources is automatically requested and a reasonable compatibility test is run. This process occurs without staff action.

Automated Renewal Process — The first step in an administrative renewal. During this step, information from electronic data sources is automatically requested, reasonable compatibility is run when income verification is required, and correspondence is sent to the recipient. This process occurs without staff action.

Availability Date — The date benefits are deposited into the recipient's Electronic Benefit Transfer (EBT) account.

Availability Period — For TANF, the availability period is two fiscal years after the benefit was issued. HHSC expunges these benefits at the end of each state fiscal year (Aug. 31).

B

Balance Receipt — A paper receipt that shows the available balance in an person's cash or food account.

Basic Utility Allowance (BUA) — Deduction given to a SNAP household that has utility costs but does not qualify for the standard utility allowance (SUA).

Batch Processing — Actions postponed until a later time when they can be processed by the system more efficiently. In many instances, batch processing occurs overnight, when Texas Health and Human Services Commission (HHSC) offices are closed and the system is not being heavily used throughout the state. Examples of batch processing include schedule system-generated correspondence to be printed at and mailed from a central site, mail out review packets at scheduled intervals from the central mail facility, and gathering information and share it through interfaces with other agencies.

Batch Scheduling — Including an appointment date and time with eligibility staff within application packets mailed from the central mail facility. See Batch Processing.

Battered Alien — A battered spouse, battered child or parent, or child of a battered person with a pending petition with the U.S. Citizenship and Immigration Services (USCIS).

BENDEX (Beneficiary and Earnings Data Exchange) — A computer tape match from the Social Security Administration that provides Social Security and Medicare information about Texas Health and Human Services Commission (HHSC) recipients. The system generates an alert when the SSA Benefit amount on file does not match the information on the BENDEX file.

Beneficiary — The person named to receive benefits.

Benefit Issuance — The functional area that supports the issuance and tracking of benefits calculated in the Eligibility Determination Benefit Calculation (EDBC) and authorized in disposition. See dispose.

Birth Verification System (BVS) — The inquiry system includes birth records of people born in Texas. Eligibility staff access BVS as a source to verify age, relationship and citizenship.

Blocked — Time periods that are designated for specific purposes. They cannot be used to schedule appointments using the **Scheduling** functional area.

Boarder — A person paying reasonable compensation for room and meals. A boarder can receive Supplemental Nutrition Assistance Program (SNAP) benefits only with the household where they board. **Note:** This does not include anyone who otherwise qualifies as a resident of a drug and alcohol treatment center, federally subsidized housing for the elderly, a qualifying group living arrangement, a shelter for battered persons, or a shelter for the homeless.

Bona Fide Agent — A person who is familiar with an applicant and knowledgeable of the person's financial affairs.

Budgetary Needs — The full basic needs amount as defined by Texas Health and Human Services Commission (HHSC) necessary for a family to obtain food, clothing, housing, utilities, and incidentals such as phone, laundry, and recreation. This calculation is based on family size and is used in the Temporary Assistance for Needy Families (TANF) 100 percent budgetary needs gross income test.

Budgeting — The method used to determine eligibility and benefits for Temporary Assistance for Needy Families (TANF), Medical Programs, and the Supplemental Nutrition Assistance Program (SNAP) by calculating income and deductions.

Business Day — Monday through Friday from 8 a.m. to 5 p.m. local time. Business day excludes Saturday, Sunday, and holidays designated by a federal or state agency.

C

Cafeteria Plan — Flexible fringe benefit plans offered to employees by their employers.

Canceled Debts — Debts that have been canceled, forgiven, or discharged. The canceled amount is included as countable income on federal income tax returns. Examples include loan foreclosures and canceled credit card debt.

Capital Gains — A profit from the sale of property or an investment when the sale price is higher than the initial purchase price. This includes profits from the sale of stocks, bonds or real estate.

Capital Goods — The accumulated possessions (property, goods and products) used to produce income or other goods.

Cardholders — Persons authorized to use the Lone Star Card to access benefits in the household's Electronic Benefit Transfer (EBT) account(s). There are two types of cardholders: primary cardholders and secondary cardholders.

Card Registration — When a cardholder requests EBT account access for a newly issued initial or replacement Lone Star Card by authenticating their identity and selecting a PIN.

Card Sleeve — A durable paper envelope folded to the dimensions of the plastic EBT card. The sleeve stores the card and protects the magnetic strip from being damaged by scratches. The sleeve also has important information printed on it for easy reference, such as the Lone Star Help Desk number.

Caretaker — For:

- Temporary Assistance for Needy Families (TANF) — An adult whose needs are included in a TANF grant because the adult is within the required degree of relationship and is financially eligible per TANF policy.
- Type Program (TP) 08, Parents and Caretaker Relatives Medicaid — A person who supervises and cares for a dependent child. The person must be a legal parent(s) or other caretaker relative within the required degree of relationship who meets the income limits for that program.

Caretaker Relative — For:

- TANF — a disqualified legal parent, second parent, or a non-parent relative certified as caretaker.
- For Type Program (TP) 08, Parents and Caretaker Relatives Medicaid — A relative within the required degree of relationship, other than a legal parent, caring for a dependent child who meets the income limits for that program.

Carryover Standby List — Applicants from a previous day's standby list who have not been interviewed.

Cascade Logic — A hierarchy of logic used to build Eligibility Determination Groups (EDGs) and evaluate eligibility for Texas Health and Human Services Commission (HHSC) programs and types of assistance. The EDG is built and eligibility is established at the highest level. If there are no eligible members after cascade logic is applied, the household is ineligible for the program. See definitions of Eligibility Determination Benefit Calculation (EDBC), rebuild EDG, run EDBC and Wrap Up.

Case — All the people living together and alien sponsors, who are related by EDG affiliation. The people may or may not be included in EDGs as certified members.

Case Mode — Status of a case that identifies that:

- action has been initiated on an EDG in a case (Intake, Complete Action, Change Action, Special Review, Conversion);
- all the EDGs in a case are approved (Ongoing); and
- all the EDGs in a case are denied (Ongoing).

Case Number — A unique 10-digit number that identifies a group of EDGs. See Case.

Case Visibility — Type of YourTexasBenefits.com account given to an applicant who has been through Advanced Authentication so is granted a Case Visibility level account. With this type of access, a person can view and change an application created under their username. They can also change any case data for cases where they are the head of household, an adult member within the household, or an authorized representative.

Catchment Area — The area covered by service.

Categorically Eligible Household — Households where all members are either eligible for or receive benefits from TANF, Supplemental Security Income (SSI), or state-financed general assistance programs. They have already gone through the eligibility determination for those programs. These households may bypass the income and resources tests and are deemed financially eligible. There are two types of categorically eligible households:

1. A Supplemental Nutrition Assistance Program (SNAP) household whose members are all approved for TANF or SSI. A household member is a TANF or SSI recipient if the person is approved for TANF or SSI but the benefit:
    - has not yet been received**;**
    - is suspended; or
    - is being recouped.
2. A SNAP household that includes members authorized to receive TANF non-cash services and whose household gross income is less than 165 percent of the Federal Poverty Limit (FPL) for its size and meets the resource criteria.

Certificate of Coverage — A certificate that serves as proof of a Medicaid recipient's most recent period of Medicaid coverage. The certificate is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is sent to denied recipients by the Texas Department of State Health Services (DSHS). Former Medicaid recipients may request a certificate within 24 months after their Medicaid is denied by calling 800-723-4789.

Certification Date — The date that eligibility staff dispose the EDG to certify an applicant.

Certification Period — The period of eligibility established at disposition. Not all HHSC programs and types of assistance have certification periods.

Certified Group — The members in an EDG who are eligible for a given program.

- SNAP and TANF — Multiple people may be certified on a single EDG.
- Medical Programs that follow modified adjusted gross income (MAGI) rules, except CHIP perinatal — Only one person is certified on the EDG.
- CHIP perinatal — The mother and child will be certified on a single EDG during the month the child is born. After, only the child will be certified on the EDG.

Change Action — A data collection interview mode that allows eligibility staff to navigate to pages on which they want to update or record information. See Case Mode.

Child — A child is an adoptive, step, or natural child who is under 19.

Child in a Two-Parent Family — For:

- TANF — A child who lives with either one or both parents, or a parent and stepparent, and one or both parents or step-parent do not receive TANF benefits.
- TANF-State Program (SP) — A child who lives with both parents, or a parent and stepparent, and both parents and stepparent (if included in the certified group) receive TANF benefits.

Child Support — A payment made from a biological or adoptive parent to a biological or adoptive child. Child support may be:

- formal – court-ordered or legally mandated; or
- voluntary – not court-ordered and given voluntarily when the child's caretaker or the person making the payment states the purpose of the payment is to support the child.

Child Support Disregard — The first $75 of the total child support collected in a month that is subtracted before determining TANF eligibility or benefits. After certification, the Office of Attorney General (OAG) sends the person the first $75 received on monthly child support collections. If the total collection is less than $75, then the amount of the collection is sent to the person .

Children's Health Insurance Program (CHIP) — Medical coverage for children under 19 whose family income exceeds the limits for Children's Medicaid.

Children's Medicaid — Medical coverage for children whose family income is under the applicable income limit. In most instances, Children's Medicaid relates to comprehensive policy for Type Programs (TPs) 43, 44, 45 and 48, unless specifically stated otherwise in a handbook section.

CHIP Perinatal — Medical services to unborn children of pregnant women ineligible for Medicaid due to income or alien status.

Choices County Service Levels — Counties designated by the Texas Workforce Commission (TWC) as Choices counties. TWC has designated all counties in Texas as Choices counties, and the Local Workforce Development Boards (LWDBs), after coordination with the HHSC state office, assign a service level designation for each county depending upon services available in that county. The two levels of service are:

- full service — having a significant presence of Choices staff; or
- minimum service — has little or no presence of Choices staff.

Claim — An amount owed by a person for an overpayment of benefits.

Clearinghouse — A centrally located site that processes medical bills submitted by applicants for Medically Needy with Spend Down. Functions of the clearinghouse include:

- determining if a medical bill can be counted for spend down;
- corresponding with the applicant about eligible and ineligible medical bills;
- determining if and when the applicant meets spend down; and
- notifying the applicant and the eligibility system when spend down is met.

Cold Call — A phone call initiated by HHSC staff to a responsible household member or AR to obtain case related information.

Collateral Call — A phone call initiated by HHSC staff to a collateral contact to obtain verification of the household's situation.

Collateral Contact — A person the advisor can contact to verify a person's information. The person's may not have a vested interest in the household's situation.

Colonias — Unincorporated and unregulated settlements (neighborhoods) along the U.S. and Mexico border.

Combat Pay — Supplemental incentive payments for hazardous duty and special pay for duty subject to hostile fire or imminent danger.

Combat Zone — The geographic area or country to which a military member is deployed for combat.

Commingled Resources — Resources of a TANF or SSI recipient combined with those of a non-TANF or SSI household member.

Common Law Marriage — Relationship where the two parties are both 18 years or older:

- are free to marry;
- live together; and
- hold out to the public that they are a married couple.

A minor child in Texas cannot legally enter a common law marriage unless the claim of common law marriage began before Sept. 1, 1997.

Communal Dining — A public or non-profit establishment approved by Food and Nutrition Services (FNS) that prepares and serves meals to elderly people or those who receive SSI and their spouses.

Community Supervision — The placement of a misdemeanor or felony offender under supervision for a specified length of time ordered by the court. Sentences are served in the community rather than in jail or prison. Also formally known as (adult) probation.

Complete Action — A data collection interview mode that sets up the driver flow for a complete review of all eligibility requirements in an ongoing case. See case mode and interview mode.

Complete Review — A re-evaluation of ongoing eligibility.

Comprehensive Energy Assistance Program (CEAP) — A utility assistance program funded annually by the Low Income Home Energy Assistance Program (LIHEAP). CEAP replaced the Home Energy Assistance Program (HEAP).

Conditional Entrant — A person granted conditional entry under Section 203(a)(7) of the INA as in effect before April 1, 1980.

Continued Benefits — Continuing or restoring benefits to the level authorized immediately before the notice of adverse action.

Continuing Scheme — A situation in which a recipient commits two or more acts. This includes falsifying a document or a statement, or providing false information in an interview, with the intent to commit fraud. Failure to report a required HHSC program change in conjunction with one or more of these acts may be considered a basis to commit fraud.

Continuous Eligibility — A period where a person remains eligible during a continuous eligibility period regardless of any change in circumstances, except for:

- reaching the maximum age for that specific program;
- death;
- voluntary disenrollment;
- change in state residence;
- state error in the eligibility determination; or
- fraud, abuse, or perjury attributed to the people or person's representative

Convertible Bond — A bond that can be converted to cash according to program policy. Convertible bonds are countable resources.

Copayment — Payment made directly to a provider according to a fee schedule.

Correspondence — The functional area in which system and user-generated notices and forms are processed and stored. The notices and forms processed in this functional area are also called correspondence and linked to a specific case. Users cannot delete system-generated correspondence. See batch processing, pending correspondence, print mode, print type, system-generated and user-generated.

Cost-Sharing Reductions — Federal payments toward out-of-pocket costs made for an eligible person enrolled in a qualified health plan (QHP) through the Marketplace.

Court Awards — Taxable money that a person receives as the result of a lawsuit, such as compensation for lost wages or punitive damages awards.

Crime Victim's Compensation — Payments from the funds authorized by state legislation to assist a person who:

- has been a victim of violent crime;
- was the spouse, parent, sibling or adult child of a victim who died as a result of a violent crime; or
- is the guardian of a victim of a violent crime.

The payments are distributed by the Office of the Attorney General (OAG) in monthly payments or in a lump-sum payment.

Cuban or Haitian Entrant — Admitted under Section 501(e) of the Refugee Education Assistance Act of 1980.

D

Data Broker — An online portal used to obtain financial and other background information about applicants and recipients. The data broker vendor collects and combines information from many data sources. This information is compared to the application and details from the interview to identify case discrepancies and reduce the possibility of case error and fraud. See Permissible Purpose.

Data Collection — The functional area where individual household, non-financial, resource, income, and deduction information is recorded for use in building Eligibility Determination Groups (EDGs) and determining eligibility for types of assistance. See EDBC and Driver Flow.

Deductible Part of Self-Employment Tax — A federal income tax deduction for self-employed people paying self-employment taxes.

Deferred Adjudication — A type of probation where the decision for a conviction is postponed until the end of the probationary period.

Dependent Child — For:

- Temporary Assistance for Needy Families (TANF) — A child who meets the definition of deprivation and who lives with a relative who meets the relationship requirement.
- Type Program (TP) 08, Parents and Caretaker Relatives Medicaid – A child who is 18 or under, and a full-time student meeting the school attendance requirement. A child who will not graduate until after the month of their 19th birthday is not considered a dependent child after the month of their 18th birthday.

Deportation (or Removal) Withheld — Deportation is being withheld under Section 243(h) of the INA, or removal is withheld under Section 241(b)(3) of the INA.

Deprivation — Loss of parental support caused by death, incapacity, continued absence of one or both natural or adoptive parents, or because of unemployment or underemployment of both parents in a two-parent family.

Derivative Citizenship — U.S. citizenship that is claimed by a person born outside of the U. S. to one or both U.S. citizen parents.

Detail Page — Click the Edit or View icon to edit or view details of a record listed on a Summary Page.

Disaster Benefits — Benefits issued to provide short-term assistance for households recovering from a disaster.

Discovery Date — The date a person learns of a change. The discovery date is compared with the report date to determine if a change is reported timely.

Dispose — To authorize an Eligibility Determination Group (EDG) so eligibility is established or denied.

Disqualified Person — Someone who is normally considered a participating member of a household but whose needs are not considered because they failed to meet or comply with a program requirement.

Domestic Production Activities Deduction — A federal income tax deduction that a person may receive for certain qualified production activities. These include construction of real property or lease, rental, license, sale, exchange, or other disposition of personal property, computer software, sound recordings, produced films, produced electricity, natural gas, or potable water.

Domicile — A home maintained or being established, as shown by continuation of responsibility for day-to-day care of the child, by the relative who the child lives.

Driver Flow — The logical sequence of data collection pages that appear as a case is completed or read. The driver flow is determined by the programs, types of assistance, and answers to questions as the case is worked. In some interview modes, staff cannot advance to pages that have not yet been accessed as part of the driver flow.

Duplicate Application — An application filed after another application has already been filed and the new application:

- does not include a request for programs different from programs requested on the initial application;
- does not include a request for programs different from programs currently received by the applicant; and
- is not needed to process a redetermination.

E

Earned Income — Income a person receives for a certain activity or work.

Earned Income Tax Credits (EITC) — Payments from the Internal Revenue Service (IRS) to people with gross monthly earnings at or below levels established by the IRS.

Educational Expenses or Student Loan Interest — A federal income tax deduction for people paying interest on student loans or for people with education expenses such as tuition, fees, room and board, books and other supplies.

Educator Expenses — Expenses for which educators, kindergarten through grade 12 teachers, counselors, principals or aides can receive a federal income tax deduction. Qualified expenses include purchased books, supplies, equipment and other classroom materials.

Effective Month — The first month benefits can be affected based on the monthly cutoff date or applicable policy for advance and adequate notice of adverse action.

Electronic Benefit Transfer (EBT) — A system that uses electronic technology to complete some of a benefit program's functional requirements. EBT involves computers, a variety of cards or types of cards, electronic funds transfer techniques, automated teller machines (ATMs), point-of-sale terminals or other types of terminals, and software to complete the EBT process without the loss of program integrity or individual confidentiality.

Electronic Benefit Transfer (EBT) Account — A benefit account established by the EBT system where HHSC deposits the household's benefits. There are three types of benefit accounts:

- an account that contains the household's Supplemental Nutrition Assistance Program (SNAP) food benefits;
- an account that contains the household's Temporary Assistance for Needy Families (TANF) cash grant amount; or
- a combined benefits account.

The person or their representative uses the Lone Star Card and a personal identification number (PIN) to access benefits in the account.

Electronic Benefit Transfer (EBT) Card — A plastic card called the Lone Star Card issued to primary and secondary cardholders that allows the cardholders access to the benefits in the EBT system. A stripe of magnetic material, which is machine-readable and allows for the activation of point-of-sale equipment, is affixed to the back of the card at the time of manufacture.

Electronic Benefit Transfer (EBT) Issuance Staff — An HHSC employee who issues and registers EBT cards for people in the local HHSC office.

Electronic Benefit Transfer (EBT) Regional Coordinator — An HHSC employee designated to oversee, monitor, lead regional planning and act as a point of contact for EBT security procedures.

Electronic Benefit Transfer (EBT) Representative — A primary cardholder other than the case name. This person has access to the EBT account for the Eligibility Determination Group (EDG). This may be a TANF representative payee or protective payee or a SNAP authorized representative for a resident of a Drug and Alcohol Treatment Center or Group Living Arrangement. See Alternate Payee.

Electronic Benefit Transfer (EBT) Site Coordinator — An HHSC employee designated to ensure local offices comply with guidelines on security and accountability operations.

Electronic Benefit Transfer (EBT) System — A system HHSC staff with security access use to issue and replace Lone Star Cards. Staff also use the EBT system to perform such functions as inquiry, account transaction update to the vendor database and, in certain very restricted situations, priority SNAP benefit authorization.

Electronic Benefit Transfer (EBT) Vendor — A company that performs EBT-related services for the state of Texas.

Electronic Data Sources (ELDS) — Verification sources that are available electronically and presented to staff in the Texas Integrated Eligibility Redesign System (TIERS) during Data Collection.

Eligibility — The functional area that supports Eligibility Determination Benefit Calculation (EDBC).

Eligibility Determination Benefit Calculation (EDBC) — The process of applying program policy to household, non-financial, resource, income and deduction information entered in the Data Collection functional area. This information is used in the EDBC process to build Eligibility Determination Groups (EDGs) and determine eligibility for programs and types of assistance. See Cascade Logic.

Eligibility Determination Group (EDG) — Members of a household whose needs, resources, income and deductions are considered in determining eligibility for benefits. The EDG includes members who are eligible and may include members who are not certified for benefits.

Emancipated Minor — A person 17 and under who has been married. The marriage must not have been annulled.

Emergency Medicaid — All types of emergency Medicaid coverage programs for people who are nonimmigrants, undocumented aliens or certain legal permanent resident aliens who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible. When the term is used in the handbook, it means all the following programs combined:

- Type Assistance (TA) 31, Parents and Caretaker Relatives – Emergency
- Type Program (TP) 32, Medically Needy with Spend Down – Emergency
- TP 33, Children 1-5 – Emergency
- TP 34, Children 6-18 – Emergency
- TP 35, Children Under 1 – Emergency
- TP 36, Pregnant Women – Emergency

Emergency Medical Condition — An eligibility requirement for Emergency Medicaid for nonimmigrants, undocumented aliens and certain legal permanent resident aliens. It is a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably have been expected to result in:

- placing the patient's health in serious jeopardy;
- seriously impairing the patient's bodily functions; or
- causing serious dysfunction of any bodily organ or part.

Employable Household Member — A person whose earnings are countable and who:

- is 16 through 59;
- does not meet the criteria in B-432, Definition of Disability; and
- is currently unemployed.

Employer-Paid Taxes — Taxes that are paid by the employer on behalf of the employee rather than deducting the tax amount from the employee's wages. The amount the employer pays is counted as part of the person's gross income.

Employment and Training (E&T) Staff — Non-HHSC staff involved in the operation of the SNAP E&T program.

Employment Services Program (ESP) — ESP consists of two programs. One program is the Choices program for TANF recipients, and the other is the SNAP Employment and Training (E&T) program for SNAP recipients. The goal of ESP is to prepare recipients for employment and help them find and keep a job.

Equity — The fair market value of an item minus all money owed on it and the cost associated with its sale or transfer.

Escrow — An escrow account is an account a mortgage company sets up for the homeowner as part of their monthly mortgage payment. The mortgage company uses money in the account to pay annual property taxes, home insurance premiums and sometimes homeowner association fees on behalf of the homeowner.

Essential Person — The need for a particular member of a household to be in the home on a continuous basis because another member has a (certified) mental or physical impairment.

Evaluative Conclusion — Staff's decision, subject to supervisory approval, to accept something other than a birth or hospital certificate or baptismal record as proof of age and relationship.

Excess Payment — A payment sent to a TANF recipient by the Office of the Attorney General (OAG). When the OAG receives a child support collection on the current monthly obligation and that payment exceeds the TANF grant plus any unreimbursed assistance, the excess is sent to the person.

Excluded Provider — A Medicaid provider who is not allowed to continue participating in the Texas Medicaid program for a period of time because of fraud conviction, program abuse and other reasons.

Expedited Service — Special, faster processing of SNAP applicants who qualify for an emergency food allotment, for active-duty military members and their dependents applying for medical coverage and for pregnant women applicants who qualify for current or ongoing medical coverage.

Expenses of Fee-Basis Government Officials — Federal income tax deductible employment-related expenses paid for or accrued by employees of a state or political subdivision who are compensated on a fee basis.

Expenses of Performing Artists — Federal income tax deductible expenses for qualified performing artists paid or accrued through performances while serving as an employee in the performing arts.

Expenses of Reservists — Federal income tax deductible expenses for National Guard and military reserve members who traveled more than 100 miles from home for service.

Expunged Benefits — Benefits that are removed from an EBT account by the issuer of the benefits.

F

Fair Hearing — A meeting conducted by a regional hearing officer with an applicant or person who disagrees with and wishes to appeal some action taken on the person’s case.

Fair Market Value — Amount of money an item would bring if sold in the current local market.

Falsified Document — Form H1010, Texas Works Application for Assistance — Your Texas Benefits (PDF); Form H1019, Report of Change (PDF); or another signed and dated document that does not report all current income or circumstances.

Falsified Interview — An interview with agency personnel when the person does not report all current income or accurate circumstances.

Falsified Statement — A statement made by a person, verbally or in writing, that is not true, such as claiming to have been without work since a certain date, when the person was employed during that period.

Family Violence — An act by a member of a family or household against another member of the family or household that is:

- intended to result in physical harm, bodily injury or assault, or that is a threat that reasonably places the member in fear of imminent physical harm or bodily injury or assault, not including defensive measures to protect oneself; or
- intended to inflict emotional harm, including an act of emotional abuse.

File Clearance — This feature determines if an applicant has a case record with HHSC. When a person is added, File Clearance can be processed in Application Registration. If File Clearance is not processed in Application Registration, the system will perform it in Data Collection. File Clearance compares the person’s demographic information against databases for potential matches. These databases contain information for people who are currently on assistance and for people who have applied for or received assistance in the past.

First Cousin Once Removed — A person who is either one's first cousin's child or the parent's first cousin.

Fixed Income — Unearned income that does not vary.

Fluctuating Income — Income where the amount varies because of an increase or decrease in hours worked, rate of pay, or inclusion of a bonus.

Four Months Post-Medical — Medicaid coverage extended for a maximum of four months after denial of a case because of spousal support income.

FPIL/FPL— A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine a household's eligibility for certain programs and benefits.

Fugitive — A person fleeing to avoid prosecution of or confinement for a felony criminal conviction or found by a court to be violating federal or state probation or parole.

Functional Area — Functions and processes that appear in the Texas Integrated Eligibility Redesign System (TIERS) Left Navigation area and represent a particular business process. Each functional area contains pages that allow authorized staff to perform activities related to the business process. The functional areas that are available to the user are determined by the user's job title and security role(s).

G

General Equivalency Diploma (GED) — A high school equivalency certificate issued after a person completes a State Board of Education-approved high school equivalency program.

General Residential Operations Facility — Residential care facilities that provide a live-in house parent model of care for children under their care. The house parent assumes responsibility and acts in lieu of the parent in meeting the children's ongoing needs. These facilities have limited power of attorney to obtain health care and educational services for the children under their care.

Good Cause — A term used to indicate that a person has an acceptable reason for not complying with a program requirement.

Grandparent Payment System (GPS) — An electronic, web-based data system used to inquire about the issuance of archived TANF one-time Grandparent Payments. The same benefit is now called One-Time TANF for Relatives, with payment records stored in TIERS.

Grant in Jeopardy — The Office of the Attorney General's (OAG's) designation for a case that is potentially ineligible for the Temporary Assistance for Needy Families (TANF) grant because the OAG received a child support collection on the current monthly obligation and it equals or exceeds the TANF grant plus the disregard.

H

Health Insurance Premium Payment (HIPP) — A reimbursement program administered by the Texas Health and Human Services Commission's (HHSC's) Third-Party Resource Unit, which pays for the cost of premiums, coinsurance, and deductibles. The program reimburses the policy holder for private health insurance payroll deductions for Medicaid-eligible persons when HHSC determines that it is cost-effective.

Health Savings Account — A savings account for medical-related expenses that is available to taxpayers. The money contributed to these accounts is not subject to federal income tax at the time of deposit.

Hearing — The functional area where individual appeals are recorded and tracked.

HHSC — The Texas Health and Human Services Commission.

HHSC IEVS Staff — HHSC eligibility field staff who process Automated System for Office of Inspector General (ASOIG) Match Texas Works Messages and MEPD Long Term Care (LTC) IEVS Matches.

High School Diploma — Certification issued by a state-accredited school to a student who successfully completes the curriculum requirements for secondary school as approved by the State Board of Education.

Historical Correspondence — Records of forms and notices that have been printed. Refer to Correspondence, Print Mode and Print Type.

Historical Data — Records of case, Eligibility Determination Groups (EDGs) and individual information.

Home Energy Assistance Program (HEAP) — A federal program that pays benefits to help eligible people pay utility costs.

Home School — A type of education where children are taught by their parents, or someone acting in parental authority, at home, using a set curriculum. The parent oversees the curriculum and ensures that the children are actually being educated.

Homeless Household — Households that have no regular nighttime residence or their primary nighttime residence is a:

- supervised shelter that provides temporary living quarters such as a welfare hotel, family violence shelter or congregate shelter;
- place not intended for regular sleeping quarters such as a hallway, bus station or lobby;
- halfway house or similar institution which provides temporary housing for people intended to be institutionalized; or
- temporary quarters in another person's home for 90 days or less. After 90 days in the same person's home, the household is no longer considered homeless.

Hotline (TANF/SNAP Complaints) — Toll-free number (877-787-8999) where staff receive complaints for Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) cases.

Housing and Urban Development (HUD) — U.S. Department of Housing and Urban Development.

I

Identical Application — One or more exact copies of an application previously submitted by an applicant.

Illegally Present Alien — A non-citizen living in the U.S. without proper approval from the U.S. Citizenship and Immigration Services (USCIS) and who has received a final order of deportation.

Immigrant — An alien who abandons residence in a foreign country to live in the U.S. as a permanent resident, for example a lawful permanent resident (LPR).

Inaccessible Resources — Resources not legally available to the person.

Independent Child — A child who does not live with a parent and who is:

- able to apply for Medicaid on the child's own behalf; or
- eligible for Medicaid because a responsible person who is not within the degree of relationship required for Temporary Assistance for Needy Families (TANF) applies on the child's behalf.

Independent Living Payments — Payments from Title IV-E funds that are distributed by Child Protective Services to certain people when they leave foster care. Payments:

- are received for a minimum of three months,
- cannot exceed $300 a month,
- cannot total more than $800, and
- are intended for expenses other than room and board.

Indian Tribal Household — A household in which at least one household member is recognized as a tribal member by any Indian tribe.

Indigent Alien — A sponsored alien whose total income in the month of application does not exceed 130 percent of the federal poverty level for the alien's household size. The following factors are considered in determining the alien's total income:

- the alien's own income;
- cash contributions of the sponsor or others; and
- the value of in-kind assistance provided by the sponsor or others.

Individual Development Accounts (IDAs) — An account similar to a savings account that enables a person to save earned income for a qualifying purpose. IDAs are generally matched dollar-for-dollar with funds from private citizens, corporations, banks, communities, or charitable organizations. The matching funds are inaccessible to the person if the funds are paid directly to a bank or loan institution, a person selling a home, or a business account.

Individual Number — A unique nine-digit number that identifies any person known to the Texas Integrated Eligibility Redesign System (TIERS).

Individual Retirement Account (IRA) — An account in which a person contributes an amount of money to supplement retirement income, regardless of their participation in a group retirement plan.

Individual Retirement Account (IRA) Deduction — A federal income tax deduction for people who contributed to a traditional IRA.

Individually Identifiable Health Information — Information that either identifies or could be used to identify a person that relates to the:

- past, present or future physical, mental health condition of the person;
- provision of health care to the person; or
- past, present or future payment for the provision of health care to the person.

Ineligible Alien — A non-citizen whose alien status makes them ineligible for program benefits.

Initial Benefits — Benefits issued for the first month of eligibility. Also benefits issued for the first month of eligibility after a break in eligibility of at least one month.

In-Kind Contribution — Any gain or benefit to a person that is not in the form of money paid directly to the person such as clothing, public housing or food.

Interview staff — Eligibility staff responsible for interviewing applicants and recipients to establish program eligibility.

Inquiry — Refers to the functional area that allows users to view case, Eligibility Determination Group (EDG), and individual information. See functional area.

Institution of Higher Education — Any public or private college, community college, junior college, technical institute, or university that usually requires a high school diploma or equivalent certificate such as a general equivalency diploma (GED), to enter.

Interactive Voice Response (IVR) — A dial-in inquiry system (also known as Automated Voice Response [AVR]) that provides 24-hour access to automated account information via a digital phone. This is a toll-free number (2-1-1 or 877-541-7905) that allows people to inquire on the status of their case, their next appointment time, or to determine if Texas Health and Human Services Commission (HHSC) received information. The caller must provide the head of household's Social Security number (SSN) or the case number and date of birth of a household member to access information.

Intentional Program Violation (IPV) — The act of intentionally making a false or misleading statement, or misrepresenting, concealing or withholding facts for the purpose of receiving assistance under the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) or Medicaid program. Also, the act of trafficking in SNAP benefits. A household member may be charged with an IPV even if the person has not actually received benefits to which they are not entitled.

Interfaces — The functional area that exchanges information with other systems and agencies.

Interview Mode — A designation in TIERS Data Collection that queues the driver flow through appropriate pages according to the type of action.

J

Judicial Review — A review of the fair hearing decision by a district court in Travis County to determine whether the agency decision is correct. A petition for judicial review must be filed by the appellant in a district court in Travis County within 30 calendar days after the date the administrative decision is issued.

Jury Duty Pay — Taxable income received as compensation for jury duty.

K

Keogh — An individual retirement account (IRA) for a self-employed individual.

L

Lawful Permanent Resident (LPR) — A person lawfully admitted for legal permanent residence in the U.S. This category also includes Amerasians admitted under Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriation Act of 1988.

Left Navigation — The list of functional areas that appears on the left side of the Texas Integrated Eligibility Redesign System (TIERS) page. A user can click the plus sign next to a functional area or sub-functional areas to display the pages available within that area.

Legal Parents — Mother, by having given birth to the child, by proof of adoption, legal document or court adjudication or father, by proof of adoption, legal document, court adjudication or his acknowledgement of paternity.

Legal Requirements — The non- financial eligibility requirements for a Temporary Assistance for Needy Families(TANF) or Medicaid child, such as age, relationship, domicile, citizenship, Social Security number (SSN), and deprivation.

Legally Obligated Child Support — Court order or a legally recorded document requiring the payments of child support to be made in the form of cash, medical support, or to a third party. The official document indicates to and for whom the support is paid, the frequency and the amount of payment.

Licensed Practitioner — A person who has met certain educational requirements and passed an examination to be licensed in the state of Texas and regulated by a state board.

Life Estate — Income a person receives from ownership of property that they only possess for the duration of their life, such as rental income.

Liquid Resources — Resources that are readily negotiable, such as cash, checking or savings accounts, Electronic Benefit Transfer (EBT) cash account, savings certificates, stocks or bonds.

Lock-in — A status created by the Texas Health and Human Services Commission (HHSC) for certain people to help contain Medicaid costs, which allows additional review of high Medicaid users. Those who see several doctors each month and make questionable visits to hospital emergency rooms are limited to seeing one doctor or using one pharmacy for a minimum of six months. Persons with illnesses that require expensive treatment are not subject to lock-in status.

Logical Unit of Work (LUW) — A set of Texas Integrated Eligibility Redesign System (TIERS) pages that must be completed before the information entered on these pages is saved. The LUW is represented by a set of tabs at the top of a TIERS page. To ensure the information is saved in an LUW in Data Collection, the user can click on the **Next** button to advance to the next LUW or on the **Previous** button to return to

the previous LUW. The user reaches the end of the driver flow at the Case Assignment page and must use the **Left Navigation** to return to specific pages in Data Collection. Clicking the **Add, Update** or **Submit** button saves information on specific pages.

Lone Star Card — See Electronic Benefit Transfer (EBT) Card.

Low Income Home Energy Assistance Program (LIHEAP) — The federal program that funds assistance for energy costs for low-income households.

Lump-Sum Payment — A financial settlement that often involves funds accumulated over an extended period and that is paid in a single payment.

M

Manage Office Resources (MOR) — The functional area that supports the administrative structure in the Texas Integrated Eligibility Redesign System (TIERS) and relationships between regional offices and their local offices, units, and employees.

Managed Care — A health care delivery system with the aim of controlling costs. In this system, patients go to their primary care physician to obtain other health services such as specialty medical care, surgery or physical therapy. Managed care includes the health maintenance organization (HMO) model.

Management — The way in which a household pays its expenses with available income.

Managing Conservator — A person designated by a court to have daily legal responsibility for a child.

Manual Voucher Transaction — A paper-based debit transaction completed by the food retailer when the automated Electronic Benefit Transfer (EBT) system is down or unavailable. A transaction may also be pre-authorized by phone.

Marketplace — The governmental entity that makes qualified health plans available to qualified people, qualified employers or both. The Marketplace in Texas is operated by the U.S. Department of Health and Human Services. The Marketplace is also known as the Exchange, Health Insurance Marketplace, and Federally Facilitated Marketplace (FFM).

Marriage — A legally or formally recognized union between two people. A same-sex marriage that occurred before June 26, 2015, is considered valid effective June 26, 2015. A same-sex marriage that occurred on or after June 26, 2015, is considered valid on the date it occurred.

Married Minor — A person, 14-17 years, who is married. These people must have parental consent or court permission. A person under 18 may not be a party to an informal (common law) marriage.

MCHIP — Medicaid eligible children, 6-18 years, whose MAGI household income is between 109 percent and 133 percent of the federal poverty limit (FPL) and for whom the state receives enhanced federal matching funds (CHIP funding). Before the implementation of the Affordable Care Act (ACA), these children were eligible for CHIP. With the implementation of the ACA, these children are eligible for Medicaid. This type of coverage is also known as CHIP-funded Medicaid expansion.

Meal delivery services — A non-profit establishment approved by Food and Nutrition Services (FNS) that prepares and delivers meals to elderly people or people who are housebound, have a physical handicap, or otherwise have a disability that prevents the person from adequately preparing all their meals.

Medicaid — A state and federal cooperative program authorized under Title XIX of the Social Security Act (United States Code [U.S.C.], Title 42, Section 1396 et seq.) and Texas Human Resources Code, Title 2, Subtitle C, Chapter 32, that pays for certain medical and health care costs for people who qualify. Medicaid is also known as the medical assistance program.

Medicaid Card – An identification card issued to people determined eligible for Medicaid that verifies Medicaid coverage.

Medicaid Report – (Form H1146) — A form completed by a transitional Medicaid household in the fourth, seventh and tenth months of medical coverage to report earnings and household composition changes.

Medical Programs — Medicaid for:

- Children Under 1 (TP 43)
- Children 1-5 (TP 48)
- Children 6-18 (TP 44)
- Newborn Children (TP 45)
- Pregnant Women (TP 40)
- Parents and Caretaker Relatives (TP 08)
- Medically Needy with Spend Down (TP 56)
- Children Under 1 – Emergency (TP 35)
- Children 1-5 – Emergency (TP 33)
- Children 6-18 – Emergency (TP 34)
- Pregnant Women – Emergency (TP 36)

- Parents and Caretaker Relatives – Emergency (TA 31)
- Medically Needy with Spend Down – Emergency (TP 32)

Medical Support — Health insurance that absent parents will be ordered to get for their children who receive Medicaid when it is available at reasonable cost. Available at reasonable cost is usually defined as being available through the employer.

Migrant Farmworker in the Workstream — Farmworkers who travel to work in agriculture or a related industry and who are presently employed away from their permanent residence or home base.

Migrant Farmworker Not in the Workstream — Farmworkers who travel to work in agriculture or a related industry during part of the year, but who are presently living at their permanent residence or home base.

Military Member — A person in the U.S. Armed Forces or Reserves (Army, Marine Corps, Navy, Air Force or Coast Guard), National Guard (Army, Marine Corps, Navy, Air Force, Coast Guard or Reserve Guard) or the State Military Forces or Texas State Guard.

Minor Child — A person under 18.

Minor Parent — A person under 18 who has a dependent.

Modified Adjusted Gross Income (MAGI) — The rules used to determine financial eligibility for certain Medical Programs that are based on Internal Revenue Service (IRS) tax rules.

Modified Adjusted Gross Income (MAGI) Financial Eligibility — The result of a comparison between an applicant's or recipient's MAGI household income to the applicable Medicaid or Children's Health Insurance Program (CHIP) income limit based on the Federal Poverty Income Limit (FPIL) and the MAGI household size.

Modified Adjusted Gross Income (MAGI) Household Composition — The people whose income and needs are considered when determining eligibility for an applicant or recipient for certain Medical Programs based on tax status, tax relationships, living arrangement, and family relationships.

Modified Adjusted Gross Income (MAGI) Household Income — The sum of every person's MAGI individual income within an applicant's or recipient's MAGI household composition, that the standard MAGI disregard is subtracted from.

Modified Adjusted Gross Income (MAGI) Household Size — The number of people in an applicant's or recipient's MAGI household composition, including the number of unborn children, if applicable.

Modified Adjusted Gross Income (MAGI) Individual Income — The sum of certain income received by a person in a MAGI household composition, where certain expenses are subtracted.

Molar Pregnancy — Also known as hydatidiform mole, a molar pregnancy is considered a degenerating pregnancy. Conception occurs, but no fetus ever develops. A molar pregnancy is considered a normal pregnancy that terminates early because of miscarriage or abortion.

Monthly Obligation — The amount of child support which the absent parent has been ordered to pay each month.

Moving Expenses — Federal income tax deductible expenses an active duty member of the military may claim for relocating to a new duty station.

N

Negative Management — A household has negative management when its reported basic expenses exceed reported net income and resources plus support the HHSC excludes, such as vendor payments.

Newborn Child — A child receiving Type Program (TP) 45, Medical Assistance for Newborn Children, because the child's mother was eligible for and received Medicaid coverage at time of the child's birth or whose mother was eligible for and received Medicaid coverage retroactively for the time of the child's birth. The newborn Medicaid coverage can continue through the month of the child's first birthday if the child continues to live in Texas.

Non-Continuous Eligibility — A period of time when changes in circumstances may affect a person's eligibility.

Nonconvertible Bond — A bond that cannot be converted to cash per program policy. Nonconvertible bonds are exempt resources.

Non-Employment and Training (E&T) Counties — Texas counties where the Texas Workforce Commission (TWC) determines it does not have enough offices to help people who are mandatory work registrants. Supplemental Nutrition Assistance Program (SNAP) applicants and people in these counties are still subject to Basic Work Rule requirements with HHSC, but are exempt from E&T participation, and not subject to SNAP federal time limits.

Non-Immigrant — An alien temporarily admitted to the U.S. for a purpose other than permanent residency, such as a religious worker or a fiancé(e) of a U.S. citizen.

Nonliquid Resources — Resources such as vehicles, buildings, land, or certain other property that are considered countable. Exceptions are as explained in the vehicles portion of resource policy or unless the resource is specifically exempted.

Non-Public Assistance (NPA) Household — Supplemental Nutrition Assistance Program (SNAP) households where no one receives Temporary Assistance for Needy Families (TANF) or only some of the members receive TANF.

Non-Secure Facility — A publicly operated community residence that serves no more than 16 residents, such as a county emergency shelter or non-public group or foster home.

Non-Traditional Retailer — A food retailer who operates in a farmer's market or as a roadside vendor.

Normal Living Expense — Items necessary for a SNAP household to carry on its normal daily activities. These items include housing, utilities, deposits for housing or utilities, food, clothing and incidentals. Incidentals include such things as normal day-to-day transportation, phone, laundry, medical supplies not paid by Medicaid, home remedies, recreation and household equipment.

Notice of Adverse Action — A notice provided to the household on TF 0002 that includes explaining the proposed adverse action, reason for the action, right to a fair hearing, and availability of continued benefits.

O

Office of Inspector General (OIG) — A division of the Texas Health and Human Services Commission (HHSC) created by the 78th Texas Legislature, Regular Session, 2003, to prevent and reduce waste, abuse, and fraud within the Texas Health and Human Services system.

Off-Line Transaction — The processing of Electronic Benefit Transfer (EBT) transactions using a manual voucher.

Ongoing Benefits — Benefits issued for months after the initial benefit month.

Opportunity to Participate — Providing a certified applicant with benefits, a Lone Star Card, personal identification number (PIN), and Electronic Benefit Transfer (EBT) training material.

Other-Related Temporary Assistance for Needy Families/Medical Program (TANF/MP) Child — An eligible child living with a relative other than the child's legal parent.

Overpayment — The amount of benefits issued in excess of what should have been issued.

Override — A Texas Integrated Eligibility Redesign System (TIERS) procedure that allows the user to make a change to the system-determined Eligibility Determination Group (EDG) results. This procedure can be used when policy has changed and TIERS has not yet been updated to process the policy change correctly. Overrides always require Second Level Review before they can be disposed.

P

Parent — A person with either a natural, biological, adopted or stepchild.

Parental Control — A minor who lives with an adult is under parental control if one of the following conditions applies:

- the adult provides more than half of the minor's total support (housing is not considered as support);
- the adult states that the adult has parental control of the minor; or
- the minor lives with an adult other than the minor's parent or legal guardian and the minor's parent or legal guardian states that the adult has parental control of the child.

  Texas Department of Family and Protective Services (DFPS) foster care parents have parental control of the foster child even if the foster child's parent moves into the home. The name of the foster parent is displayed as Alternate Payee on the foster care Eligibility Determination Group (EDG) summary page in the Texas Integrated Eligibility Redesign System (TIERS).

Parole— The discretionary and conditional release of an eligible offender sentenced to serve the remainder of the sentence under supervision in the community rather than prison.

Parolee — A person paroled into the U.S. under section 212(d)(5) of the INA for at least one year.

Participation Status — The designation of an Eligibility Determination Group (EDG) member as an eligible or ineligible member of the certified group. The participation status indicates whether the person is considered an adult or a child according to policy.

Passive Renewal — A process by which the Texas Integrated Eligibility Redesign System (TIERS) automatically recertifies a Former Foster Care in Higher Education (FFCHE) active Eligibility Determination Group (EDG) for another certification period. This process occurs through a mass update and does not require action.

Payee — A person that the Temporary Assistance for Needy Families (TANF) benefits are issued to if no one in the household qualifies or wants to be a caretaker. The payee must be within the required degree of relationship.

Payments to Civilians Relocated During Wartime — Payments made to Aleuts or people of Japanese ancestry or their heirs who were relocated during World War II.

Penalty on Early Withdrawal —A federal income tax deduction for people who withdrew money from a time-deposit savings account before the certificate maturing and who were charged a penalty for early withdrawal.

Pending — Awaiting conclusion.

Pending Correspondence — Forms or notices that have been generated on a case and are waiting to be processed in batch. All system-generated correspondence is sent to pending correspondence, but it can be retrieved and printed locally. Once correspondence is printed, whether in batch or locally, the record of the printing is stored in **History Correspondence** functional area. See Print Mode.

Periodic Income Check (PIC) — The process to determine whether electronic data indicates that there has been a change in the Modified Adjusted Gross Income (MAGI) household income that could make the recipient ineligible for certain Medical Programs. Changes in income identified through this process may impact eligibility for other programs.

Permissible Purpose — A federal requirement that allows staff to legally request a credit report from the Data Broker system for the sole purpose of determining eligibility. Permissible purpose means the person whose credit report is requested must be:

- an applicant or a certified Temporary Assistance for Needy Families (TANF);
- Supplemental Nutrition Assistance Program (SNAP) or Medical Program household member or a member who would be certified but is disqualified; or
- a Medical Program Modified Adjusted Gross Income (MAGI) household member.

Staff who request credit information without permissible purpose are subject to fines, imprisonment, or both. They are also subject to disciplinary action from the Texas Health and Human Services Commission (HHSC).

Personal Account Number (PAN) — The 19-digit number on the front of the Lone Star Card representing the person's Electronic Benefit Transfer (EBT) account number on the EBT database. The PAN is not related to the person's Texas Health and Human Services Commission (HHSC) case number.

Personal Identification Number (PIN) — A four-digit numeric code assigned to each cardholder and used to control access to the person's account. The PIN must be entered on a keypad before any electronic transaction can be processed.

Personal Identification Number (PIN) Security — Actions cardholders should take to prevent others from gaining access to their PIN and Electronic Benefit Transfer (EBT) account. Instructions include not writing their PIN on the card sleeve or anything they carry in their purse or wallet, not revealing their PIN to anyone, or letting anyone use their card.

Personal Possessions — Possessions that include furniture, appliances, jewelry, clothing, livestock, farm equipment, and other items that an applicant uses to meet personal needs essential for daily living.

Personal Representative — A person who can represent another person's rights with respect to individually identifiable health information. Only a personal representative may authorize the use or disclosure of individually identifiable health information or obtain individually identifiable health information for a person.

Personal Responsibility Agreement (PRA) — A requirement for Temporary Assistance for Needy Families (TANF) that certain people must follow the conditions of the agreement. Noncompliance with the PRA results in a sanction.

Point-of-Sale (POS) Transaction — An electronic transaction using an Electronic Benefit Transfer (EBT) card to make a purchase, a cash withdrawal, or inquiry.

Power of Attorney (POA) — Written legal authorization to represent or act on another's behalf in private affairs, business, or some other legal matters.

Practitioner — A person who holds a license to practice medicine, including a physician (M.D.), osteopathic medical physician (D.O.), dentist (D.D.S.), advanced nurse practitioner (A.N.P.) or registered nurse (R.N.). **Note:** A licensed vocational nurse or licensed practical nurse does not meet the definition of practitioner.

Prepaid Burial Insurance — Insurance that pays for a specific funeral arrangement. Also known as a pre-need plan or prepaid funeral agreement.

Preschool Children — Children who are under six.

Presumptive Eligibility (PE) — Short-term Medicaid coverage provided to people determined potentially eligible for regular Medicaid by a qualified hospital or a qualified entity. This coverage is provided temporarily while the Texas Health and Human Services Commission (HHSC) determines eligibility for regular Medicaid.

Primary Cardholder (PCH) — The person designated to receive and be responsible for the household's Lone Star Card. A household may designate a secondary cardholder who has a Lone Star Card and access to the household's Electronic Benefit Transfer (EBT) account. The

primary cardholder is usually the Eligibility Determination Group (EDG) name, but the EDG may have an alternate payee who is the primary cardholder.

Print Mode — Indicates where historical correspondence was printed. Batch and Online are the types of print modes. Batch is correspondence managed by batch processing and printed at a central mail facility. All system-generated correspondence is scheduled for batch printing although it can be retrieved from Pending Correspondence and printed locally.

Print Type — Classification of historical correspondence as the original record or a reprint of the original. Each original correspondence is given a unique Correspondence ID (identifying number). Each reprint of an original has the same Correspondence ID as the original.

Priority Supplemental Nutrition Assistance Program (SNAP) Issuances — Expedited SNAP benefits, benefits issued on or after the 25th day from the date of application, and issuances ordered by a hearing officer decision that must be made available in order to meet fair hearing timeliness requirements. These issuances are available to the person the same day the Eligibility Determination Group (EDG) is disposed.

Processing Time Frames — Number of days eligibility staff must complete a particular action.

Proration — Portion of total monthly benefits a household is entitled to receive.

- Temporary Assistance for Needy Families (TANF) proration is based on the number of days between the begin date of eligibility and the end of the first month of eligibility.
- Supplemental Nutrition Assistance Program (SNAP) proration is based on the number of days between the file date and the end of the month.

Prospective Budgeting — Determination of eligibility for and the amount and type of benefits using the best estimate of the household's current and future circumstances and income.

Protective Payee — Person selected to receive and manage the Temporary Assistance for Needy Families (TANF) benefit when the caretaker is not using the TANF payments for the children's benefit. See Alternate Payee.

Prudent Person Principle — Reasonable decision made by staff based on the best information available and common sense in a particular situation.

Public Assistance (PA) Household — A Supplemental Nutrition Assistance Program (SNAP) Eligibility Determination Group (EDG) in which:

- all eligible members receive Temporary Assistance for Needy Families (TANF) or Refugee Cash Assistance (RCA); or
- some eligible members receive TANF or RCA, and all other eligible members receive Supplemental Security Income (SSI), including SSI essential persons.

Public Institution — A facility that is either an organizational part of a governmental entity or over which a governmental unit exercises final administrative control. Examples of public institutions include county and city jails and Texas Department of Corrections prisons. Inmates of facilities that meet the definition of public institution are not eligible for Temporary Assistance for Needy Families (TANF) or Medicaid. **Note:** See Publicly Operated Community Residence for additional information about a public facility not considered to be a public institution.

Publicly Operated Community Residence — A facility designed to serve up to 16 residents and to provide some services beyond food and shelter, such as social services, training in socialization, and life skills. An example of a publicly operated community residence that is not a public institution is a county homeless shelter with a capacity of up to 16 people. Residents of a publicly operated community residence are potentially eligible for Temporary Assistance for Needy Families (TANF) and Medicaid. They are not considered inmates of a public institution.

Even if designed to serve up to 16 residents, the following facilities are not considered publicly operated community residences:

- a facility located on the grounds of or immediately adjacent to any large institution or multi-structure complex;
- an educational or vocational training institution; and
- a correctional or holding facility for people who:
  - are prisoners;
  - have been arrested or detained pending disposition of charges; or
  - are held under court order as material witnesses or juveniles.

Q

Qualified Entity (QE) — A Medicaid provider (in most instances but can also be an organization such as a school or clinic) that notifies HHSC of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations for pregnant women only, per HHSC policies and procedures. Qualified entities that are also Breast and Cervical Cancer Services (BCCS) contractors with the DSHS may make presumptive eligibility determinations for Medicaid for Breast and Cervical Cancer (MBCC) applicants.

Qualified Health Plan (QHP) — A private insurance plan that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing (such as deductibles, copayments, and out-of-pocket maximum amounts), and meets certain other

requirements.

Qualified Health Professional — A person who provides care under the supervision of a licensed practitioner or a medical or dental practice that is state regulated.

Qualified Hospital (QH) — A Medicaid provider that notifies HHSC of its intent to make presumptive eligibility determinations and agrees to make PE determinations per HHSC policies and procedures. The qualified hospital may choose to make PE determinations for pregnant women, children under 19, parents and caretaker relatives of dependent children under 19, and former foster care children.

Quality Control — The functional area that supports the state's approach to quality control and allows authorized staff to enter sample selection criteria. Based on the criteria, TIERS generates a sample list.

Questionable Information — Information that is contradictory or incomplete.

Questionable Management — A household has questionable management when reported basic expenses exceed reported net income and resources.

R

Radiation Exposure Payments — A program to compensate a person for injury or death from exposure to radiation from nuclear testing and uranium mining. Make payments to the surviving spouse, children, parents, grandchildren or grandparents when the affected person is deceased.

Range of Payment — The highest to the lowest representative pay amounts used to determine the current ongoing budget.

Reactivation Date — The effective date to reinstate benefits for an Eligibility Determination Group (EDG). Enter this for various situations including:

- denied in error;
- continued benefits for a denied EDG;
- reinstating Transitional Medicaid Assistance (TMA); and
- reactivating an EDG without requiring a new application form.

Real Property — Land and any improvements on it.

Reapplication —

- Timely – Supplemental Nutrition Assistance Program (SNAP) application filed by the 15th of the last month of certification. This is also called a timely recertification or redetermination.
- Untimely – SNAP application filed after the 15th of the last certification month. Treat an untimely reapplication the same as an initial application.

  Note: Verification requirements are the same for both timely and untimely applications.

Reapplication Date — Date the Texas Health and Human Services Commission (HHSC) receives a new application for redetermination or complete review of eligibility.

Reasonable Compatibility — The method of verification used for Medical Programs. It compares an applicant’s statement of income against income provided by electronic data sources.

Reasonable Opportunity — The 95-day period following the date a notice is sent to a person. This gives a source of citizenship or alien status verification for certain Medical Programs.

Rebuild EDG — A button in the Wrap Up management group. It is used to apply cascade logic by reforming EDGs until establishing eligibility. Refer to EDBC and Run EDBC.

Reception Log — The functional area in the Texas Integrated Eligibility Redesign System (TIERS) where office contacts by phone, mail, fax and in-person can be recorded.

Recognizable Needs — The maximum needs amount allowed by HHSC when determining eligibility.

Recoupment — Withholding part of a person's current benefit because of a previous overpayment.

Redetermination — A complete action to determine eligibility for a new certification period in a program.

Refugee — A person admitted to the U.S. under Section 207 of the INA.

Reimbursement — Repayment for a specific item or service.

Reinstatement — Process of providing TMA to a household denied because of failure to return a complete Medicaid Report.

Replacement Benefits — Benefits issued in certain situations. They replace a previously authorized issuance received by the household.

Report Date — The date information is reported to HHSC. Eligibility Determination Benefit Calculation (EDBC) uses the discovery and report dates to determine if a required report of change is reported timely.

Reports — The functional area that:

- collects information from throughout TIERS; and
- produces reports that meet HHSC, state and federal reporting requirements.

Representative Payee — In Temporary Assistance for Needy Families (TANF), a person designated to receive and manage the household's benefits for someone who is incapacitated or incompetent. Refer to Alternate Payee.

Resident Seasonal Farmworkers — Farmworkers who do not leave their permanent home to work in agriculture or a related industry.

Resources — Both liquid and nonliquid assets a person can convert to meet immediate needs.

Responsible Household Member — A household member who can help provide eligibility verification, complete the interview or report changes for the household's case.

Restored Benefits — Full or partial months of benefits for a past month owed to a household due to an agency error.

Retroactive Benefits — Initial benefits issued for a month before the application is certified.

Review —TANF evaluative interview. It must take place before the person receives a seventh warrant.

Roomer — A person paying reasonable compensation for room but not meals.

Royalty — A payment to a person for permitting another to use or market property. This includes mineral rights, patents or copyrights.

RSDI — Retirement, Survivors and Disability Insurance benefits (RSDI) paid by the Social Security Administration.

Run EDBC (Eligibility Determination Benefit Calculation) — A process in the Wrap Up eligibility management group used to determine eligibility of the EDG. Refer to EDBC.

S

Sanction — Either a disqualification or a penalty applied to a case or program because a person failed to follow a program requirement.

Scheduling — The functional area that manages eligibility appointments. See Batch Scheduling.

Second Chance Home — An adult-supervised living arrangement that provides independent living services to teen mothers and their children. Independent living services may include, but are not limited to:

- case management;
- counseling, mentoring;
- parenting skills;
- child development;
- childcare services;
- school-to-work transition services; and
- family reunification services.

Second Level Review — Review of a case by a second party before the Eligibility Determination Group (EDG) is disposed. The second party selects the Second Level Review interview mode.

Second Parent — This is the parent who is not the caretaker. It is when a child lives with both legal parents and both parents are requesting and are eligible for coverage.

Secondary Cardholder (SCH) — A person designated by the primary cardholder as eligible to access the person's Electronic Benefit Transfer (EBT) account with a second EBT card and personal identification number (PIN).

Secure Facility — Secure boot camp settings. These include a county holding facility for juveniles or a facility that a government unit exercises final administrative authority.

Self-Employed Health Insurance — A federal income tax deduction for self-employed people paying for health insurance for themselves, their spouse, their tax dependents, or their child(ren) under 27.

Self-Employed Individual Retirement Account (IRA), Simple IRA, and Qualified Plan Deductions — A federal income tax deduction for self-employed people or partners in a business.

Self-Employment Income — Earned or unearned income available from one's business, trade or profession rather than from an employer.

Self-Service Portal (SSP) — A web-based application, at YourTexasBenefits.com. It's available to applicants and Community Partners helping applicants to:

- perform initial self-screening to check for potential eligibility;
- apply for benefits online;
- check application status;
- check benefit and appointment status;
- upload supporting documents;
- make case changes;
- submit redeterminations; and
- view general benefit program information.

Also referred to as YourTexasBenefits.com.

Sibling — Brother or sister, including legally adopted and half-brothers and half-sisters.

Social Security Number — A unique nine-digit number assigned to a person by the Social Security Administration (SSA). The number is used to record covered wages, track Social Security benefits and for other identification purposes.

Special Immigrant Conditional Permanent Resident (SI CPRs) — Qualified noncitizens granted special immigrant status. They will become lawful permanent residents (LPRs) upon the removal of their conditions by the Department of Homeland Security (DHS).

Special Immigrant Iraqi and Afghan (SIV) — A special immigrant status under 101(a)(27) of the INA may be granted to Iraqi and Afghan people who have worked on behalf of the U.S. government in Iraq or Afghanistan. The Department of Defense Appropriations Act of 2010, PL 111-118, enacted on Dec. 19, 2009, says SIV are eligible for all benefits to the same extent and the same period as refugees.

Special Review — A procedure to explore one or more areas of eligibility. This includes management and medical, at a specified time other than at application or complete action. A special review is conducted in Special Review mode. See Interview Mode and Case Mode.

Spend Down — The amount of excess income that the applicant must deplete with incurred medical bills before being certified as medically needy.

Spouse — A person who:

- is married; or
- lives with another person and they represent themselves to the community as married. See Common Law Marriage.

Standard MAGI Income Disregard — An income disregard equal to five percentage points of the Federal Poverty Income Limit (FPIL) for the applicable Modified Adjusted Gross Income (MAGI) household size.

Standard Medical Expense — A deduction applied to a Supplemental Nutrition Assistance Program (SNAP) budget. It’s given to an elderly household member, a household member with a disability, or both, who incur medical expenses of more than $35 but less than or equal to the standard deduction amount.

Standard of Need — Basic needs of Temporary Assistance for Needy Families (TANF) families represented by a figure predetermined by the state of Texas per the number of certified people in the group. This figure represents food, clothing, housing, utilities and incidentals. Incidentals include normal day-to-day transportation, phone, laundry, medical supplies not paid by Medicaid, home remedies, recreation and household equipment.

Standard Utility Allowance (SUA) — A standard deduction for the cost of utilities. These are given to a SNAP household that either incurs a heating or cooling cost separate from the rent or received a Low-Income Home Energy Assistance Program (LIHEAP) payment.

Standby List — Applicants who are awaiting an interview without a specific appointment. See Carryover Standby List.

State Data Exchange (SDX) — Computer tape from the Social Security Administration (SSA). It gives Supplemental Security Income (SSI) and Medicaid information on Texas Health and Human Services Commission (HHSC) people. Social Security information is also available for people who receive SSI or Medicaid. SDX information can be used as a source of verification and is available in the Texas Integrated Eligibility Redesign System (TIERS).

State Online Query — SOLQ allows states real-time online access to SSA's SSN verification service. SOLQ enables state social services to rapidly get information they need to qualify people for programs.

Step Grandparent — The spouse of a blood-related grandparent.

Streamlined Reporting (SR) — Households where all adults are exempt from the 18-50 work requirements due to:

- disability;
- having a child under 18;

- is a member of a SNAP EDG where a household member is under 18; or
- being pregnant meet the SR criteria.

Note: These households receive a six-month certification period.

Subsistence — Life supporting or survival.

Sufficient Employment — Job earnings, other than seasonal work such as migrant or seasonal farm work, that would result in TANF ineligibility without including the 90 percent earned income disregard .

Summary Page — A page that lists a summary of all records available for the TIERS page. See Detail Page.

Supplemental Benefit — Additional benefits for a current month given to a household during a month the Texas Health and Human Services Commission (HHSC) already issued initial or ongoing benefits.

Supplemental Nutrition Assistance Program (SNAP) — Past name was the Food Stamp Program.

Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP) — A demonstration project that outreaches elderly Supplemental Security Income (SSI) recipients who are not currently certified for SNAP.

Supplemental Security Income (SSI) — A needs-tested program administered by the Social Security Administration. It provides monthly income to aged people and persons who are blind or have a disability.

Suspended Benefits — The EDG is flagged to prevent the ongoing issuance of benefits until eligibility staff review the EDG.

System-Generated — Created by a computer system programmed with given parameters. For example, a notice is system-generated when an EDG is disposed. The notice contains programmed information based on the program, type of assistance, and eligibility result. See User-Generated.

T

Tax Dependent — A person who expects to be claimed by someone else as a dependent on a federal income tax return for the taxable year that Medicaid or Children's Health Insurance Program (CHIP) eligibility is requested. See Taxpayer.

Taxable Year — The 12-month period that a person uses to report income for federal income tax purposes. For most people, their tax year is the calendar year. A calendar tax year is 12 consecutive months beginning Jan. 1 and ending Dec. 31.

Taxpayer — A person or a married couple who expects:

- to file a federal income tax return for the taxable year in which Medical Program eligibility is requested;
- if married, to file a joint federal income tax return for the taxable year in which Medical Program eligibility is requested;
- that no other taxpayer will be able to claim the person or the couple as a tax dependent on a federal income tax return for the taxable year in which Medical Program eligibility is requested; or
- to claim a personal exemption deduction on the taxpayer’s federal income tax return for one or more applicants. This may or may not include the person or the person’s spouse.

Temporary Assistance for Needy Families (TANF) – Basic — Cash assistance for families that include a dependent child and no more than one eligible adult. The Eligibility Determination Group (EDG) name must be within the required degree of relationship to the dependent child.

Temporary Assistance for Needy Families (TANF) Certified Child — A child who is included in a TANF grant.

Temporary Assistance for Needy Families – Non-Cash (TANF-NC) — Consists of services for:

- family planning;
- adult education;
- the prevention and treatment of substance abuse;
- employment services;
- domestic violence; and
- Women, Infants, and Children (WIC) nutrition.

Temporary Assistance for Needy Families (TANF) Redirect — A Texas Works message to TANF applicants delivered up front by Texas Health and Human Services Commission (HHSC) staff before the application process begins, explaining that:

- TANF is temporary and has time limits;
- there are other alternatives and options for the applicant instead of TANF benefits;
- an applicant should consider jobs and other resources (such as child support) before pursuing TANF;
- if an applicant chooses to apply for assistance, the person is requesting help finding a job; and
- even if an applicant chooses not to apply for TANF, the person can still apply for Medical Programs and the Supplemental Nutrition Assistance Program (SNAP) to support employment while working toward self-sufficiency.

Temporary Assistance for Needy Families – State Program (TANF-SP) — Cash assistance for families with a dependent child and at least two adults. Adults on the Eligibility Determination Group (EDG) must be legal parents (including a certified stepparent) to the dependent child. This includes legal parents and stepparents who are disqualified for one of the reasons listed in A-222, Who Is Not Included, No. 4, Disqualified Members, unless that disqualification is due to not meeting citizenship requirements.

Ten-Ten-Thirteen Concept — Time periods used to determine the first month of an over-issuance claim. The person has 10 days to report the change; staff have 10 days to act on the change. The notice of adverse action expires in 13 days.

Texas Health Steps — A health care program of prevention, diagnosis, and treatment for Medicaid people.

Texas Integrated Eligibility Redesign System (TIERS) — A computer system used to:

- store individual and case information;
- process eligibility determinations for multiple programs based on data provided through direct input and interfaces with other systems;
- generate benefit issuance;
- assist users in monitoring and managing workload; and
- create correspondence and reports based on system-requested and user-requested criteria.

Texas Simplified Application Project (TSAP) — TSAP is a simplified application and certification process for SNAP. All members of a TSAP household must not receive earned income and must be either elderly or disabled as defined by SNAP program rules. People can apply using a simplified application, and they do not typically have to complete an interview at redetermination. TSAP provides a 36-month certification period.

Texas Workforce Commission (TWC) — The state governmental agency charged with overseeing and providing workforce development services to employers and job seekers of Texas. TWC is part of a local and state network dedicated to developing the workforce of Texas. The network is comprised of the statewide efforts of TWC along with planning and service provision by 28 local workforce boards on a regional level.

The Workforce Information System of Texas (TWIST) — The computer system used by the Texas Workforce Commission (TWC) for intake, eligibility determination, assessment, service tracking, and reporting of TWC-administered programs, such as child care, Supplemental Nutrition Assistance Program (SNAP), Employment and Training, Choices, and the Workforce Innovation and Opportunity Act.

Third Party — Person or organization outside the certified household.

Third-Party Resource — A source of payment of medical expenses other than the recipient or the Texas Health and Human Services Commission (HHSC).

Three Months Prior — The three-month period before the Medicaid application month. Applicants who meet eligibility requirements during any of the months in this period receive Medicaid benefits for the eligible month(s).

Time Limit — The functional area where Temporary Assistance for Needy Families (TANF) state and federal time-limited months can be viewed. Authorized staff can correct months in this functional area.

Timely Disposed — An Eligibility Determination Group (EDG) that is completed in accordance with program timeliness standards.

Tip Income — Income earned along with wages paid by patrons to people employed in service-related occupations. These occupations include beauticians, waiters, valets and food delivery staff.

Trade Adjustment Assistance Act Program (TAAP) — A program for workers displaced by foreign workers.

Trafficking Supplemental Nutrition Assistance Program (SNAP) —

- The buying, selling, stealing, or otherwise effecting an exchange of SNAP benefits for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone. These benefits are accessed by:
  - Electronic Benefit Transfer (EBT) cards;
  - card and personal identification numbers (PINs); or
  - manual voucher and signature.
- Attempting to buy, sell, steal, or otherwise effect an exchange of SNAP benefits and using them for cash or something other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone. These are benefits issued and accessed by EBT cards, card numbers and PINs, or by manual voucher and signature
- The exchange of firearms, ammunition, explosives, or controlled substances, defined in Section 802 of Title 21, United States Code, for SNAP benefits.
- Purchasing a product with SNAP benefits with a container requiring a return deposit. The intention is to get cash by purposely discarding the product and returning the container for the deposit amount.
- Purchasing a product with SNAP benefits with the intent of obtaining cash or something other than eligible food. This is done by intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food.
- Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

Trafficking Victims — Victims admitted under the Trafficking Victims Protection Act of 2000.

Transitional Medical Assistance (TMA) — Medicaid coverage provided after denial of certain Eligibility Determination Groups (EDGs) because of new or increased earnings or new or increased spousal support income. EDGs denied because of new or increased earnings will receive a maximum of 12 months of coverage. EDGs denied because of new or increased spousal support income will receive a maximum of four months of coverage.

Trust — Property held by one person for the benefit of another.

Tuition or GI Bill Deduction — A federal income tax deduction for people who paid qualified tuition fees to eligible post-secondary educational institutions for themselves, their spouse or their dependents.

Type of Assistance (TOA) — The specific aid for one or more people in an Eligibility Determination Group (EDG). For example, the Supplemental Nutrition Assistance Program (SNAP) has two types of assistance: PA (public assistance) and NPA (non-public assistance).

U

Underpayment — Issuance of fewer benefits than an individual is entitled to receive.

Undocumented Alien — An alien living in the U.S. without the knowledge and permission of the U.S. Citizenship and Immigration Services (USCIS).

Unearned Income — Payments received without performing work-related activities, including benefits from other programs.

Unreimbursed Assistance — Money paid in prior months in the form of public assistance under the Title IV-A program (that is, under the current Temporary Assistance for Needy Families [TANF] program or the former Aid to Families with Dependent Children [AFDC] program) that has not yet been recovered from collections that are applied to assigned arrears.

U.S. Citizenship and Immigration Services (USCIS) — The government agency that oversees lawful immigration to the U.S. In 2003, USCIS officially assumed responsibility for the immigration service functions of the federal government. The Homeland Security Act of 2002 dismantled the former Immigration and Naturalization Service (INS) and separated the former agency into three components within the Department of Homeland Security. The:

- USCIS provides immigrant services;
- Immigration and Customs Enforcement handles immigration enforcement; and
- Customs and Border Protection is responsible for border security functions.

User-Generated — Action generated directly by an individual's computer input. For example, a user can:

- request an alert and send it to another user;
- generate manual correspondence on a case; and
- generate a manual issuance of benefits outside the normal eligibility process.

User Guide — A Texas Integrated Eligibility Redesign System (TIERS) help tool accessed by clicking on the Help icon in the upper right corner of TIERS pages. The User Guide includes information about numerous TIERS topics.

V

Vendor Payment — Payment made directly to the household's creditor or person providing the service by a person or organization outside the household.

Vested Interest — A situation or circumstance to which a person has a strong personal commitment.

Vested Retirement Account — An account to which an employee makes contributions for a specified period of time as defined by the employer. The employer does not match the money contributed by the employee until the defined period of time ends.

Veteran — A person who has served in the United States armed forces such as Army, Marine Corps, Navy, Air Force, Space Force, Coast Guard, and National Guard. This includes a person who served in a reserve component of the armed forces and who was discharged or released, regardless of the conditions of their discharge or release.

Voluntary Quit — Leaving a job without good cause.

W

Waiver Counties — Texas counties with an unemployment rate over 10 percent. Supplemental Nutrition Assistance Program (SNAP) applicants and individuals in these counties are not subject to SNAP federal time limits because of the job market. They are still required to be registered for work with the Texas Workforce Commission (TWC) and are mandatory participants if they do not meet work registration exemption requirements.

Waiver of Continued Benefits — An individual option to allow eligibility staff to process an adverse action during the individual's appeal process.

Welfare-to-Work — A federal program designed to support state and local efforts to move hard-to-employ Temporary Assistance for Needy Families (TANF) recipients into unsubsidized jobs and promote their self-sufficiency.

Workforce Innovation and Opportunity Act — A federal program to streamline state workforce development systems combining job training, adult education and literacy, and vocational rehabilitation. The Workforce Innovation and Opportunity Act replaced the Workforce Investment Act of 1998.

Wrap Up — The Texas Integrated Eligibility Redesign System (TIERS) program page in Data Collection where Eligibility Determination Groups (EDGs) are built and the Eligibility Determination Benefit Calculation (EDBC) is run to determine the highest level of eligibility or ineligibility. See Cascade Logic, Rebuild EDG, and Run EDBC.

TWH Forms

TWH Documents and Notices

Body

Documents

This section includes a variety of supporting documents that are not official HHS forms and may not be fillable. They are programs' responsibility to create and maintain and include instructional, informational or procedures.

Effective Date	Title
7-01-26	Texas Works Documentation Guide (PDF)
6-01-26	Social Security Administration Benefits for People with Disabilities Receiving TANF (English PDF) Social Security Administration Benefits for People with Disabilities Receiving TANF (Spanish PDF) Social Security Administration Benefits for People with Disabilities Receiving TANF Instructions (PDF)
3-01-26	Explanation of Child Support Eligibility Requirements Family Violence and Good Cause FAQs (English PDF) Explanation of Child Support Eligibility Requirements Family Violence and Good Cause FAQs (Spanish PDF)

Notices

This section makes the most current notices available with a single resource. Notices are used to provide information. They remain in the handbook until the notice is no longer necessary.

Effective Date	Title
7-01-24	TF0610, Notice of Excessive Card Replacements

TWH Revisions

26-3, July Quarterly Revision

Body

Revision Notice 26-3, Effective July 1, 2026

Archived Revision 26-2, Effective April 1, 2026 (PDF)
Archived Revision 26-1, Effective Jan. 1, 2026 (PDF)
Archived Revision 25-4, Effective Oct. 1, 2025 (PDF)
Archived Revision 25-3, Effective July 1, 2025 (PDF)

Revisions

The following sections were revised in the Texas Works Handbook:

Section	Title	Change
A-122	Filing the Application	Clarifies file date for applications submitted by phone. (All Programs)

Section	Title	Change
A-132	Eligibility Factors	Updates school attendance as eligibility criteria. (Emergency Parent and Caretaker Relatives Medicaid)
A-232.2	Disqualified People	Updates address for OIG Benefits Program Integrity (BPI) mailbox. (All Programs)
A-251	Verification Sources	Corrects Related Policy link. (All Programs)
A-823	Lock-In Status	Corrects OIG contact information. (Medical Programs)
A-1323.1	Children's Earned Income	Updates section to align with policy in A-1341. (Medical Programs)
B-232	Establishing a Secondary Cardholder	Clarifies Lone Star Help Desk secondary cardholder policy. (SNAP and TANF)
B-232.1	Secondary Cardholder Established by the Lone Star Help Desk	Clarifies Lone Star Help Desk secondary cardholder policy. (SNAP and TANF)
B-474.1.2	Medical Programs	Corrects Related Policy link. (Medical Programs)
B-1270	Documentation Requirements	Corrects links. (All Programs)
C-321	Current TANF State Time Limit County Hardship List	Updates the TANF State Time Limit County Hardship Lists to reflect the current quarter. (TANF)
C-322	Previous TANF State Time Limit County Hardship Lists	Updates the TANF State Time Limit County Hardship Lists to reflect the last three previous quarterly dates. (TANF)
D-1731	Exceptions to the Continuous Enrollment Period	Clarifies continuous enrollment policy. (CHIP)
D-1761	Involuntary Disenrollment	Clarifies continuous enrollment policy. (CHIP Perinatal)
Texas Works Documentation Guide	TWH Documents and Notices	Updates documentation requirements to reflect current Texas Works policy. (All Programs)

Forms

The following forms were revised in the Texas Works Handbook:

Form No.	Title	Change
Form H1010 Instructions	Texas Works Application for Assistance – Your Texas Benefits	Clarifies signature requirement for D&A and GLA cases.
Form H1133	Account Verification	Retires form from handbook.

26-2, April Quarterly Revision

Body

Revision Notice 26-2, Effective April 1, 2026

Archived Revision 26-1, Effective Jan. 1, 2026 (PDF)
Archived Revision 25-4, Effective Oct. 1, 2025 (PDF)
Archived Revision 25-3, Effective July 1, 2025 (PDF)

Revisions

The following sections were revised in the Texas Works Handbook:

Section	Title	Change
A-122.2	Scheduling Appointments	Incorporates policy from Medicaid for the Elderly and People with Disabilities (MEPD) and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-131	Interviews	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-131.3	Interview Requirements	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)

Section	Title	Change
A-133	Rights and Responsibilities	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-140	Expedited Service	Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
A-145	Expedited Certification Procedures	Updates cross-references. (SNAP)
A-145.1	Postponed Verification Procedures	Moves information here from deleted B-116.1. Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
A-150	Combined Allotment Policy	Changes title to Combined Allotments. Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
A-160	Joint TANF-SNAP Applications	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-190	Documentation Requirements	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-611	At Application	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-612	Redetermination	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-630	Documentation Requirements	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-841	General Eligibility Information	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-950	Documentation Requirements	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-1110	General Policy	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-1122.1	Parent Profile Questionnaire	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-1130	Explanation of Good Cause	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-1131.1	Good Cause for Family Violence Option	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-1541	Periodic Redeterminations and Special Reviews	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-2020	Authenticating a Caller	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-2020.1	Authentication Questions and Verification Sources	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-2020.2	Actions When Unable to Authenticate the Caller	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-2020.3	Actions on Inaccurate Responses to the Questions	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)

Section	Title	Change
A-2020.4	Claiming Hardship for Coming to the Office	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-2020.5	Actions When Verification Is Provided at the Local Office	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-2020.6	Denial for Failure to Authenticate Identity	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-2040.1	Authentication of Caller Identity Verification Sources	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-2050	Documentation Requirements	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
A-2322	Benefits	Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
A-2342	Denial at Redetermination	Clarification and plain language updates.(Medical Programs)
A-2344.1	Form TF0001 Required (Adequate Notice)	Updates cross-references. (SNAP)
B-114	Missed Appointment	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
B-116.1	Information Received During Expedited Application Processing	Deletes section. (SNAP)
B-120	Redeterminations	Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
B-121	Notice of Redetermination Certification Expiration	Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
B-122	Processing Redeterminations	Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
B-122.3.1	Denied for Missed Appointments	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
B-122.4	Medical Program Administrative Renewals	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
B-124	Processing Untimely Redeterminations	Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
B-126	Processing Desk Reviews	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
B-622	When to Report	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
B-642.2	Verification Not Provided Timely	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)
B-940	Texas Works Responsibilities	Updates language and contact information. (All Programs)
C-131.1	Federal Poverty Level (FPL)	Updates the federal poverty level (FPL). Adjusts amounts used for eligibility determinations for some Medicaid programs. Reflects 2026 amounts.
C–131.3	Transitional Medicaid	Updates the federal poverty level (FPL). Adjusts amounts used for eligibility determinations for some Medicaid programs. Reflects 2026 amounts.
C–131.4	Standard MAGI Income Disregard	Updates the federal poverty level (FPL). Adjusts amounts used for eligibility determinations for some Medicaid programs. Reflects 2026 amounts.

Section	Title	Change
C–131.5	IRS Monthly Income Thresholds	Updates the federal poverty level (FPL). Adjusts amounts used for eligibility determinations for some Medicaid programs. Reflects 2026 amounts.
C-1114	Guidelines for Providing Retroactive Coverage for Children and Medical Programs	Updates title to Guidelines for Providing Retroactive Coverage for Medical Programs. Updates the federal poverty level (FPL). Adjusts amounts used for eligibility determinations for some Medicaid programs. Reflects 2026 amounts.
W-914	Automatic Eligibility Determination for HTW	Incorporates policy from MEPD and TW Bulletin 25-19, Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives, released on Nov. 04, 2025. (Medical Programs)

Forms

The following forms were revised in the Texas Works Handbook:

Form No.	Title	Change
Form H0011-R and Instructions	Texas Simplified Application Project (TSAP) for SNAP Food Benefits Renewal	Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
Form H1010-R	Your Texas Works Benefits – Renewal Form	Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)
Form H1105 and Instructions	SNAP Expedited Screening Sheet	Incorporates policy from MEPD and TW Bulletin 25-19, SNAP Treatment of Application and Recertification Timeframes (START), released on Nov. 04, 2025. (SNAP)

Retired Bulletins

The following bulletins are deleted from the Texas Works Handbook since the information has either been incorporated into the handbook or is no longer necessary:

Release Date	Bulletin No.	Title
11-04-25	25-19	1. Remove Interview Requirement for Medicaid for Parents and Caretaker Relatives (PDF) 2. SNAP Treatment of Application and Recertification Timeframes - START (PDF)
10-24-25	25-18	Allowing Limited Scope Policy Premiums as Incurred Medical Expenses (PDF)
10-20-25	25-17	Aligning Federal and State In-Kind Support and Maintenance Policies (PDF)
08-01-25	25-14	Transfer of Assets Divisor (PDF)
02-14-25	25-03	Asset Verification System and TIERS Updates (PDF)
02-05-25	25-01	Revised - Mileage Rate Increase (PDF)

26-1, January Quarterly Revision

Body

Revision Notice 26-1, Effective Jan. 1, 2026

Archived Revision 25-4, Effective Oct. 1, 2025 (PDF)
Archived Revision 25-3, Effective July 1, 2025 (PDF)
Archived Revision 25-2, Effective April 1, 2025
Archived Revision 25-1, Effective Jan. 1, 2025 (PDF)

Revisions

The following sections were revised in the Texas Works Handbook:

Section	Title	Change
A-122.2	Scheduling Appointments	Updates Languages.
A-820	Regular Medicaid Coverage	Clarifies language for Emergency TOAs. Updates language.
A-823	Lock-In Status	Updates language and contact information for the HHSC Lock-In Program. (Medical Programs)
A-825	Medicaid Termination	Clarifies language for Emergency TOAs. Updates language.

Section	Title	Change
A-1531.5	Compliance Requirements	Clarifies requirements including good cause reasons.
A-1822.2	Exempt Members Volunteering to Participate in E&T	Clarifies documentation requirements for household members exempt from E&T. (SNAP)
A-1890	Documentation Requirements	Clarifies E&T documentation requirements. (SNAP)
A-2310	Notice to Applicants	Adds note for updated policy change and related policy link. (Medical Programs)
A-2311	General Information for Denials and Terminations	Creates a new section. Adds definitions for denials and terminations. (All Programs)
B-161	DataMart Reports	Removes duplicate section. (All Programs)
B-341.1	Procedures for Issuing Agency Replacements	Clarifies the difference in Agency Replacements and Unauthorized Use Replacements. (SNAP)
B-382	Client Inquiries	Clarifies households disputing EBT transactions must contact the Lone Star Help Desk to request a second review. (TANF and SNAP)
B-382.2	Balance Disputes	Clarifies how households can report a balance dispute. (TANF and SNAP)
B-412	Student Eligibility Requirements	Makes minor edits for clarity. (SNAP)
B-443.2	EBT Regional and Site Coordinator Responsibilities	Updates mailbox address and makes minor edits for clarity. (SNAP)
B-472	Special Treatment for Households Meeting Categorical Eligibility Criteria	Updates language.
B-621	What to Report	Clarifies SR 1 and SR 2 criteria. (SNAP)
C-840	DataMart Reports	Removes outdated reference to staff resources. (All Programs)
C-841	DataMart Reports	Removes references to outdated DataMart reports. Adds descriptions for existing DataMart report DF-012 (All Programs)
C-1052.4	Access Control Systems	Updates section for safeguarding FTI to align with IRS findings. (All Programs)
D-110	General Policy	Incorporates policy from MEPD and TW Bulletin 24-06, CHIP Perinatal (CHIP-P) and Emergency Medicaid During the Pregnancy and 12-month Postpartum Period, released on July,1 2024. (CHIP and CHIP-P)
D-1435	Pregnancy Reports	Incorporates policy from MEPD and TW Bulletin 24-10, House Bill (H.B.) 12 Children's Health Insurance Program (CHIP) Updates, released on Aug. 1, 2024. (CHIP)
D-1720.1	Enrollment Packets	Removes references to expedited CHIP enrollment. Changes title to Enrollment Fees.

Forms

The following forms were revised in the Texas Works Handbook:

Form No.	Title	Change
Form H1072 Instructions	ABAWD Employment and Training Work Requirement Verification	Incorporates policy from MEPD and TW Bulletin 23-14, New ABAWD Age Criteria, released on Sept. 15, 2023. (SNAP)
Form H1073 and Instructions	Personal Responsibility Agreement (PRA)	Makes minor updates to form and removes signature line for staff. Updates instructions language.

Retired Bulletins

The following bulletins are deleted from the Texas Works Handbook. The information was either incorporated into the handbook or is no longer necessary:

Release Date	Bulletin No.	Title
07-31-24	24-09	Face-to-Face Interview Informing
07-01-24	24-06	CHIP Perinatal (CHIP-P) and Emergency Medicaid During the Pregnancy and 12-Month Postpartum Period
09-01-15	14-05	Federally Required Eligibility Changes for Medicaid and CHIP (September 2015 Update)

25-4, October Quarterly Revision

Body

Revision Notice 25-4, Effective Oct. 1, 2025

Archived Revision 25-3, Effective July 1, 2025 (PDF)
Archived Revision 25-2, Effective April 1, 2025
Archived Revision 25-1, Effective Jan. 1, 2025 (PDF)
Archived Revision 24-4, Effective Oct. 4, 2024 (PDF)

Revisions

The following sections were revised in the Texas Works Handbook:

Section	Title	Change
A-930	Requirement for Unmarried Minor Parents to Live with an Adult or in an Adult-Supervised Setting	Makes minor edits for clarity. (TANF)
A-931	Failure to Comply	Makes minor edits. (TANF)
A-940	Verification Sources	Changes section title to Verification Requirements, corrects section location. Makes minor updates for clarity. (Medical Programs and TANF)
A-941	Verification Sources	Makes minor edits for clarity. (Medical Programs and TANF)
A-1311	Requirement to Pursue Income	Incorporates policy from Medicaid for the Elderly and People with Disabilities (MEPD) and TW Bulletin 25-11, Requirement to Apply for Other Benefits, released on June 13, 2025. (Medical Programs)
A-1311.1.2	Social Security Administration Definitions and Guidelines	Incorporates policy from MEPD and TW Bulletin 25-11, Requirement to Apply for Other Benefits, released on June 13, 2025. (Medical Programs)
A-1380	Documentation Requirements	Incorporates policy from MEPD and TW Bulletin 25-11, Requirement to Apply for Other Benefits, released on June 13, 2025. (Medical Programs)
A-1429.4	Phone Standard	Changes title to Telephone Standard and incorporates policy from MEPD and TW Bulletin 25-15, 2. SNAP Income Limits, Deductions, and Allotments, released on Sept. 5, 2025. (SNAP)
A-1940	ABAWD Work Requirement	Clarifies the definition of work for able-bodied adults without dependents (ABAWD). (SNAP)
A-1980	Documentation Requirements	Incorporates policy from MEPD and TW Bulletin 23-14, New ABAWD Age Criteria, released on Sept. 15, 2023. (SNAP)
A-2341	Denial of an Application	Updates continuous eligibility policy. Adds related policy link. (Medical Programs)
A-2342	Denial at Redetermination	Updates continuous eligibility policy and adds related policy link. (Medical Programs)
A-2342.1	Retesting Eligibility	Clarifies eligibility policy. Adds related policy link. (All Programs)
B-122.3.2	Denied for Failure to Provide Information or Verification	Makes minor edits for clarity (SNAP)
B-475.1	Overview	Incorporates policy from MEPD and TW Bulletin 25-15, 3. SNAP-CAP Shelter Threshold and Allotments, released on Sept. 5, 2025. (SNAP-CAP)
C-111	Income Limits	Incorporates policy from MEPD and TW Bulletin 25-15, 1. TANF Maximum Grant Amounts, released on Sept. 5, 2025. (TANF)
C-121	Maximum Income Limits	Incorporates policy from MEPD and TW Bulletin 25-15, 2. SNAP Income Limits, Deductions, and Allotments, released on Sept. 5, 2025. (SNAP)
C-121.1	Deduction Amounts	Incorporates policy from MEPD and TW Bulletin 25-15, 2. SNAP Income Limits, Deductions, and Allotments, released on Sept. 5, 2025. (SNAP)
C-122	How to Determine Monthly SNAP Allotments	Incorporates policy from MEPD and TW Bulletin 25-15, 2. SNAP Income Limits, Deductions, and Allotments, released on Sept. 5, 2025. (SNAP)
C-123	How to Prorate Benefits	Incorporates policy from MEPD and TW Bulletin 25-15, 2. SNAP Income Limits, Deductions, and Allotments, released on Sept. 5, 2025. (SNAP)
C-814	Merge and Separate	Corrects mailbox address and program area name. (All Programs)
C-825.13	Texas Workforce Commission (TWC) Wages and Benefits	Makes update to TWC information for clarity. (All Programs)
C-1431	Whole Monthly Allotments by Household Size	Incorporates policy from MEPD and TW Bulletin 25-15, 2. SNAP Income Limits, Deductions, and Allotments, released on Sept. 5, 2025. (SNAP)
Glossary	Glossary A	Incorporates policy from MEPD and TW Bulletin 23-14, New ABAWD Age Criteria, released on Sept. 15, 2023. (SNAP)

Forms

The following forms were revised in the Texas Works Handbook:

Form No.	Title	Change
H1822 Instructions	ABAWD Employment and Training Work Requirement Verification	Incorporates policy from MEPD and TW Bulletin 23-14, New ABAWD Age Criteria, released on Sept. 15, 2023. (SNAP)

Retired Bulletins

The following bulletins are deleted from the Texas Works Handbook. The information was either incorporated into the handbook or is no longer necessary:

Release Date	Bulletin No.	Title
3-31-23	23-08	1. COVID-19 Update: Change of Address 2. COVID-19 Update: Returned Mail
03-31-23	23-06	COVID-19 Update: COVID-19 Assistance Payments
02-01-22	22-02	1. COVID 19 Update: Additional Emergency Allotment Supplement 2. COVID-19 Update: Processing Denial Actions for Medicaid Programs 3. Medicaid for Inmates of Juvenile Institutions 4. Mileage Rate Increase
05-12-20	20-13	COVID-19 Policy Updates #8
04-28-20	20-10	COVID-19 Policy Updates #7
03-23-20	20-04	COVID-19 Policy Updates #1

TWH Policy Bulletins

Body

This section ensures that the most current policy and procedures are accessible through a single resource. Memoranda containing policy or procedural information is added to the Policy Bulletin list at the time of distribution and remains available until the information is fully incorporated into the handbook. Email AES_RDS@hhs.texas.gov if a bulletin was removed from this list before full incorporation, or for access to older versions.

Release Date	Bulletin No.	Title
09-16-26	26-16	1. TANF Maximum Grant Amounts (PDF) 2. FY 27 SNAP Cost of Living Updates (PDF) 3. Lottery and Gambling Winnings (PDF) Attachment: 2027 SNAP Allotment Chart (PDF)
09-08-26	26-15	1. Remove Continuous Eligibility from Transitional Medicaid (PDF) 2. H.R. 1 Changes to Alien Medicaid Eligibility (PDF) 3. H.R. 1 Changes to Alien Medicaid Eligibility - SSI Population (PDF) 4. Texas Health Steps and Health Care Orientation Medicaid Eligibility Update (PDF)
08-14-26	26-14	1. Removal of Fixed Certification Periods for CHIP and CHIP-Perinatal (PDF) 2. Processing Time Frames for CHIP Renewals Update (PDF)
08-07-26	26-13	Automated Death Matches for Single Person Households (PDF)
07-03-26	26-12	Revised - Income Verification Policy Update: The Work Number (PDF)
06-19-26	26-11	Pre-release Application Processing (PDF)
06-01-26	26-10	1. Interest Income Updates (PDF) 2. Spousal Impoverishment Dependent Allowance (PDF)
05-22-26	26-09	SNAP Streamlined Reporting Requirements (PDF)
04-13-26	26-08	1. Self-Attestation for Family Violence Good Cause (PDF) 2. Updates to the Absent Parent LUW (PDF) 3. Updates to the Tax Status LUW (PDF) 4. ABAWD Functionality Enhancements (PDF)
03-20-26	26-07	SNAP Purchase Restrictions (PDF)
03-05-26	26-06	1. Apply Ex Parte Process for Recipients Aging Out of Children's Health Insurance Program - CHIP (PDF) 2. Apply Ex Parte Process for Recipients Aging Out of Healthy Texas Women - HTW (PDF)
03-02-26	26-05	Mileage Rate Increase (PDF)
02-19-26	26-04	2026 Federal Poverty Level (PDF)
02-11-26	26-03	Termination of Parole for Certain Immigrants and Immediate Family Members (PDF)
02-05-26	26-02	H.R. 1 SNAP Alien Eligibility Impact (PDF)

Release Date	Bulletin No.	Title
06-17-26	26-01	Revised - Asset Verification System (AVS) and Additional TIERS Updates (PDF)
12-29-25	25-24	Federal Benefits 2026 Cost-of-Living Adjustment - COLA (PDF)
03-05-26	25-23	Revised - Mandatory Shelter Costs Verification (PDF)
11-14-25	25-22	Federal Government Shutdown Update (PDF)
11-10-25	25-21	Partial November SNAP Allotments (PDF)
		Attachment: SNAP Allotment Chart November 2025 Partial Benefits (PDF)
11-10-25	25-20	Low-Income Home Energy Assistance Act of 1981 - LIHEAA (PDF)
10-01-25	25-16	House Resolution 1 ABAWD Exceptions and Age Limit Change (PDF)
		Attachment: SNAP Work Rules Informing Script - English (PDF)
		Attachment: SNAP Work Rules Informing Script - Spanish (PDF)
09-05-25	25-15	1. TANF Maximum Grant Amounts (PDF)
		2. SNAP Income Limits, Deductions, and Allotments (PDF)
		3. SNAP-CAP Shelter Threshold and Allotments (PDF)
		Attachment: SNAP Allotment Chart (PDF)
07-22-25	25-13	Compacts of Free Association (COFA) Eligibility (PDF)
07-01-25	25-12	1. Update - Asset Verification System and TIERS Updates (PDF)
		2. Spousal Impoverishment Dependent Allowance (PDF)
06-13-25	25-11	Requirement to Apply for Other Benefits (PDF)
06-02-25	25-10	Update - Continuous Eligibility for Medicaid for Children Under 19 - Department of Family and Protective Services (DFPS) - (PDF)
05-23-25	25-09	SNAP and TANF Telephonic Signatures (PDF)
04-01-25	25-08	SNAP Work Rules – Verbal Informing Documentation (PDF)
04-01-25	25-07	1. Removal of Fixed Certification Periods for Texas Works Medicaid Programs (PDF)
		2. Processing Time Frames for MAGI Renewals Update (PDF)
03-21-25	25-06	Timely Change Reporting (PDF)
03-10-25	25-05	Flexibility: SNAP Change of Address (PDF)
02-25-25	25-04	2025 Federal Poverty Level (PDF)
12-27-24	24-18	Update - SNAP Unauthorized Use Replacement Benefits (PDF)
12-20-24	24-17	Federal Benefits 2025 Cost-of-Living Adjustment (COLA) - (PDF)
12-13-24	24-16	Additional Updates to Asset Verification System (PDF)
12-27-24	24-15	Revised - Update - Continuous Eligibility for Medicaid for Children Under 19 (PDF)
11-18-24	24-14	1. Extension of the Medicaid for Breast and Cervical Cancer (MBCC) Certification Period
		2. Update - Eligibility for Federal Benefits for Ukrainian Humanitarian Parolees (UHPs)(PDF)
10-04-24	24-13	Updates to Asset Verification System as Verification (PDF)
10-01-24	24-12	1. TANF Maximum Grant Amounts
		2. SNAP Income Limits, Deductions, and Allotments (PDF)
		Attachment: SNAP Allotment Chart (PDF)
08-01-24	24-10	House Bill (H.B.) 12 Children's Health Insurance Program (CHIP) Updates (PDF)
07-18-24	24-08	Asset Verification System as Verification (PDF)
07-17-24	24-07	Spousal Impoverishment Dependent Allowance (PDF)
04-17-24	24-04	1. End of SNAP Shelter Cost Flexibility: Change of Address
		2. End of SNAP Shelter Cost Flexibility: Returned Mail
		3. COVID-19 Update: Interview Requirements (PDF)
05-24-23	23-10	SNAP Unauthorized Use Replacement Benefits (PDF)
03-31-23	23-08	1. COVID-19 Update: Change of Address (PDF)
		2. COVID-19 Update: Returned Mail (PDF)
03-31-23	23-07	End of Continuous Medicaid Coverage
		1. Maintaining Medicaid Coverage
		2. Processing Case Actions for Medical Programs
		3. Reasonable Opportunity Period (ROP)
		4. Medicaid Buy-In and Medicaid Buy-In for Children Premiums
		5. Renewals Initiated Prior to April 1, 2023
		6. SNAP Income to Renew Medicaid
02-10-23	23-03	Updates to Afghan Eligibility for Federal Benefits
11-08-22	22-18	1. COVID-19 Update: Change of Address During the COVID-19 Public Health Emergency (PHE) and the PHE Unwinding Period (PDF)
		2. COVID-19 Update: Returned Mail During the COVID-19 Public Health Emergency (PHE) and the PHE Unwinding Period (PDF)
		3. Residence Verification Requirements for Former Foster Care Children (PDF)
08-04-22	22-14	Eligibility for Federal Benefits for Ukrainian Humanitarian Parolees (UHPs)
01-03-22	22-01	1. Updates to Managed Care Organizations (MCO) Preferred Method of Contact
		2. SNAP-CAP Allotment Adjustment
		3. COVID-19 Update: Additional Emergency Allotment Supplemental

Release Date	Bulletin No.	Title
12-14-18	18-10	1. Removal of Fleeing Felon and Parole/Probation Violator Application Questions 2. Maternal Depression Screening Questions 3. Suspension, Termination and Reinstatement of Health Care Coverage for Persons Confined to a County Jail
10-01-14	15-02	Interstate Compact on the Placement of Children (ICPC)

TWH Contact Us

Body

For technical or accessibility issues with this handbook, please email the HHS Form & Handbook Request mailbox.

For questions about the Texas Works Handbook (TWH), email the HHSC Texas Works Policy Support mailbox.