January-May 2017 Summary of Changes

Chapter	Passage	Summary
1410	**1420.1001**	Deleted the ninth month and replaced it with last month as eligible for Temporary Cash Assistance due to pregnancy. Deleted the section of notes that defined the ninth month and replaced with clarification of third trimester. Deleted the section of example that counted back three months for the third trimester and update the example to include the ninth month.
1430	**1430.0115** **1440.0115** **1440.0103**	Removed "or reapplication" from all 3 passages. Added passage to include "Data from the Federal Data Services Hub" may be used to verify U.S. citizenship and identity for Medicaid.
1450	**1450.0115**	Removed "or reapplication" from all 3 passages.
1630	**1640.0406**	Adding "Do not count income as an asset in the month received. This does not apply to SSI lump sums (see 2640.0421). Any income which is not spent in the month received becomes an asset the month following the month of receipt. Therefore, when determining asset value in a particular month, it may be necessary to deduct income added to the asset that same month."
1650	**1650.0406, 1660.0406**	Adding "Do not count income as an asset in the month received. This does not apply to SSI lump sums (see 2640.0421). Any income which is not spent in the month received becomes an asset the month following the month of receipt. Therefore, when determining asset value in a particular month, it may be necessary to deduct income added to the asset that same month."
1810	**1810.0918, 1820.0918**	Deleted text and added language to clarify that reparation payments are excluded in the eligibility determination process because of the person's status as a victim of Nazi persecution.
1830	**1840.1302**	Changed the word oral to verbal in 1. Removed the word the in 5. Deleted the word two and added the word four in Contributions to a Facility section.

2000	**2030.0800** **2030.0812.01** **2030.0812.02** **2030.0812.03** **2040.0812.02** **2040.0815.02** **2050.0800** **2050.0812.01** **2050.0812.02** **2050.0812.03**	Added the title section for Retroactive Med (MFAM) Added Retroactive Medicaid Added Requirements for Retroactive Coverage Added Date of Entitlement for Retroactive Medicaid Added Requirement #5 Removing verbiage from number 1, which state, "…but no older than 59" to "…be at least 18 years of age or older (must meet disability criteria if under age 65);" Added the title section for Retroactive Med (CIC) Added Retroactive Medicaid Added Requirements for Retroactive Coverage Added Date of Entitlement for Retroactive Medicaid
2200	**2210.0317.03** **2210.0318.03**	Deleted text and added language specifying what information is to be reported to the state agency when an individual leaves a treatment facility and the time frame for reporting that information. Added language that requires the facility to provide the resident with a change report form to report the change in circumstance to the state agency within 10 days. Added language specifying what information is to be reported to the state agency when an individual leaves a treatment facility and the time frame for reporting that information. Added language that requires the facility to provide the resident with a change report form to report the change in circumstance to the state agency within 10 days.
2400	**2430.0201** **2440.0201** **2450.0201**	Removed reference to verifying actual income in a month that has already passed
2600	**2640.0118**	Adding verbiage to include personal needs allowance supplement (PNAS) to Institutionalized Hospice cases. "…For Institutionalized Hospice, the PNA is $105. If the individual has less than

		$105 total countable income, a supplemental payment must be authorized through the SPS. The PNAS cannot exceed $75 a month…"
3200	**3210.0101, 3220.0101**	Added a note on clarification of an authorized/designated representative
	3210.0111.02	Deleted text and added language that specifies the time frame in which the EBT card must be returned either to the individual or the state agency. Deleted text and added language that defines the amount of the monthly allotment that is to be returned to the EBT account when an individual leaves a facility.
	3230.0102	Removed "Authorizations of designated representatives are valid for the current review period only."
	3240.0115	Removed "Authorizations of designated representatives are valid for the current review period only."
	3260.0101	Added a note on clarification of an authorized/designated representative

1420.1001 Pregnancy Policy (TCA)

A pregnant woman may be eligible for Temporary Cash Assistance (TCA) due to pregnancy if:

1. she has no other children for whom assistance is requested,
2. the unborn is deprived, and
3. she is in her ~~ninth~~ last month of pregnancy, or is in her third trimester and unable to participate in work activities.

   Note: ~~The ninth month is defined as the calendar month in which the due date falls~~. The third trimester begins ~~three months prior to the month the baby is due~~ the seventh month.

   Example: If a woman is pregnant and due June 14, ~~the eligibility specialist would count back three months from June (May, April and March) to determine when~~ the third trimester ~~begins, which~~ would begin in ~~March~~ April.

Note: Pregnant women residing in the home with deprived children applying for assistance will have their application for temporary cash ~~and~~ determined on the needs of the assistance group regardless of their stage of pregnancy.

The father of the unborn child living in the home with no other children may not receive TCA under the two-parent policy until after the baby is born.

Pregnant women eligible for TCA must still work register unless they meet an exemption from work registration.

1430.0115 VIS-CPS (MFAM)

VIS-CPS must be completed for noncitizens:

1. at application ~~or reapplication~~,
2. when adding a noncitizen individual, and
3. any time there is a change to alien status.

A noncitizen who has what appears to be a "good" USCIS document, when VIS-CPS indicates contradictory information, will be considered potentially eligible until secondary verification is returned confirming the status. Do not hold, deny or terminate benefits waiting for the secondary verification.

1440.0103 Verification Sources for U.S. Citizens (MSSI, SFP)

United States citizenship must be verified for all individuals who claim to be citizens, including those who are naturalized and those born abroad to U.S. citizens.

Exceptions: Individuals who receive SSI, any part of Medicare, Social Security Disability based on their work history and children in the care of the Department are exempt from this requirement. If we have verification in our records, do not ask for it again, unless it appears fraudulent.

The following sections discuss what documents may be accepted as verification of U.S. citizenship and identity.

The following can be used to document U.S. citizenship and identity:

1. A U.S. passport (can be expired),
2. A Certificate of Naturalization (DHS form N-550 or N-570),
3. A Certificate of Citizenship (DHS form N-560 or N-561),
4. Data from the Driver's And Vehicle Express (DAVE) system ~~or~~
5. Data from the Federal Data Services Hub (FDSH).

The following can only be used to verify citizenship (must show a U.S. place of birth):

1. BVS record (MNOV or DEBP) if born in Florida,
2. VIS-CPS (SAVE) for naturalized citizens (must have their A#),
3. Verification of eligibility under the Child Citizenship Act of 2000, including the U.S. citizenship of the parent,
4. A U.S. birth certificate (originally issued prior to age five) (except for voided Puerto Rican birth certificates after September 30, 2010),
5. A final adoption decree, or if the adoption is pending and no birth certificate can be issued, a statement from the state adoption agency (U.S. born children),
6. A Report of Birth Abroad of a U.S. citizen (forms FS-240, FS-545 or DS1350),
7. A U.S. Citizen I.D. card (DHS form I-197 or I-179),
8. A Northern Mariana ID card (I-873),
9. An American Indian card (I-872, with "KIC" code),
10. Proof of civil service employment before 6/1/76, or
11. Official military record of service (ex.DD-214).

If none of the above documents exist or can be located, the following documents can be used to verify U.S. citizenship if they show a U.S. place of birth and are dated five years prior to the Medicaid application (unless for a child under age five):

1. Extract of hospital birth record on hospital letterhead (not a souvenir birth certificate),
2. Life or health insurance record with a U.S. place of birth,
3. Early school record, or
4. Religious record (ex baptism) within three months of birth.

If none of the above documents exist or can be located, the following documents can be used to verify U.S. citizenship if they show a U.S. place of birth and are dated five years prior to the Medicaid application (unless for a child under age five):

1. Federal census records from 1900-1950 showing the age and place of birth (the five year rule does not apply),
2. Tribal census records,
3. An amended birth certificate, after age five,
4. A signed statement from the doctor or midwife who was present at the birth,
5. Nursing home institution records that contain biographical information,
6. Medical records with biographical information,
7. Listed on the roll of Alaskan natives, or

A written statement signed under penalty of perjury by at least two people who have personal knowledge of the event(s) – (One cannot be related.). They must also prove their own citizenship and identity. A separate statement by the applicant/recipient/representative, signed under penalty of perjury, must also be completed stating why the documentation could not be obtained.

1440.0115 VIS-CPS (MSSI, SFP)

VIS-CPS must be completed for noncitizens:

1. at application ~~or reapplication~~,
2. when adding a noncitizen individual, and
3. any time there is a change to alien status.

A noncitizen who has what appears to be a "good" USCIS document, when VIS-CPS indicates contradictory information, will be considered potentially eligible until secondary verification is returned confirming the status. Do not hold, deny or terminate benefits waiting for the secondary verification.

1450.0115 VIS-CPS (CIC)

VIS-CPS must be completed for noncitizens:

1. at application ~~or reapplication~~,
2. when adding a noncitizen individual, and
3. any time there is a change to alien status.

A noncitizen who has what appears to be a “good” USCIS document, when VIS-CPS indicates contradictory information, will be considered potentially eligible until secondary verification is returned confirming the status. Do not hold, deny or terminate benefits waiting for the secondary verification.

1640.0406 Determining Asset Value (MSSI, SFP)

The amount of the asset included is the actual value of the asset minus indebtedness. Indebtedness is the amount needed to satisfy contract terms that must be met to establish ownership of the asset. Do not count income as an asset in the month received. This does not apply to SSI lump sums (see 2640.0421). Any income which is not spent in the month received becomes an asset the month following the month of receipt. Therefore, when determining asset value in a particular month, it may be necessary to deduct income added to the asset that same month.

Cash value and indebtedness determinations will be discussed for each type of asset.

1650.0406 Determining Asset Value (CIC)

The amount of the asset included is the actual value of the asset minus indebtedness. Indebtedness is the amount needed to satisfy contract terms that must be met to establish ownership of the asset. Do not count income as an asset in the month received. This does not apply to SSI lump sums (see 2640.0421). Any income which is not spent in the month received becomes an asset the month following the month of receipt. Therefore, when determining asset value in a particular month, it may be necessary to deduct income added to the asset the same month.

1660.0406 Determining Asset Value (RAP)

The amount of the asset included is the actual value of the asset minus indebtedness. Indebtedness is the amount needed to satisfy contract terms that must be met to establish ownership of the asset. Do not count income as an asset in the month received. This does not apply to SSI lump sums (see 2640.0421). Any income which is not spent in the month received becomes an asset the month following the month of receipt. Therefore, when determining asset value in a particular month, it may be necessary to deduct income added to the asset that same month.

Cash value and indebtedness determinations will be discussed for each type of asset.

1810.0918 Victims of Nazi Persecution ~~German~~/Japanese/Aleutian Payments (FS)

Payments to victims of Nazi persecution are excluded as income. These payments include, but are not limited to, reparation from Germany, Austria, and the Netherlands. As long as payments to individuals are based on their status as victims of Nazi

persecution, the payment will be disregarded in the eligibility determination. ~~German reparation and~~ Japanese and Aleutian restitution payments are also excluded as income.

1820.0918 Victims of Nazi Persecution ~~German~~/Japanese/Aleutian Payments (TCA)

Payments to victims of Nazi persecution are excluded as income. These payments include, but are not limited to, reparation from Germany, Austria, and the Netherlands. As long as payments to individuals are based on their status as victims of Nazi persecution, the payment will be disregarded in the eligibility determination. ~~German reparation and~~ Japanese and Aleutian restitution payments are also excluded as income.

1840.1302 Contributions (MSSI, SFP)

All direct money payments from any source that represent gain or benefit to the individual are included as unearned income.

A contribution is cash received by any member of the standard filing unit. A contribution may be received on a one-time basis or on regular or irregular intervals.

An allowance is considered a contribution when paid to an individual by a person outside the individual's standard filing unit. This would apply to money from a non-legal father when there is a legal father.

The individual must provide verification of the amount received as a gift or contribution. When written verification is unavailable, documentation must include the following information:

1. date ~~oral~~ verbal verification received,
2. source of verification,
3. source of funds,
4. date made, and
5. ~~the~~ amount.

Standard verbal verification policy applies. If the individual is unable to obtain verification, discuss with the individual. The eligibility specialist should then use the best information available and record this in CLRC.

Contributions to a Facility:

For OSS, contributions made to the facility on behalf of the individual are not considered as income as long as the payment is made directly to the facility and does not exceed ~~two~~ four times the recognized cost of care.

Note: Social Security does consider contributions as income (in-kind support and maintenance) to determine the amount of an SSI payment. If an OSS applicant/recipient's SSI is decreased, rejected or terminated because of contributions to the facility, the OSS payment cannot be increased to offset the SSI reduction.

2030.0800 RETROACTIVE MEDICAID (MFAM)

The following passages will discuss Retroactive Medicaid requirements and the date of entitlement for Retroactive Medicaid.

2030.0812.01 Retroactive Medicaid (MFAM)

DCF may authorize Medicaid coverage for any one or more of the three calendar months preceding the month of application for ongoing Medicaid benefits when the requirements are met.

2030.0812.02 Requirements for Retroactive Coverage (MFAM)

The following requirements must be met in order to be eligible for retroactive Medicaid:

1. The individual must file an application for ongoing assistance. A request can be made for a deceased individual.
2. In the retroactive period, the individual must have received medical services which would be reimbursable by Medicaid. The individual's statement that he has unpaid medical bills for any of the three months will be accepted; the individual is not required to verify that the bills exist or that the services will be covered by Medicaid.
3. The eligibility specialist will determine eligibility for each of the retroactive month(s) using eligibility criteria for any Medicaid coverage group, regardless of the program for which the individual applied.
4. A determination of eligibility must be made for each of the month(s) in the period.
5. Once current income has been verified and any discrepancies resolved, staff must accept self-attestation that the individual’s income was consistent during the retroactive period. Request additional information only if the income is inconsistent or information known to the agency suggests the individual’s circumstance may have changed in the retroactive period.

2030.0812.03 Date of Entitlement for Retroactive Medicaid (MFAM)

The period of entitlement for each retroactive month is the calendar month for which eligibility is established; that is, if the individual is determined to be eligible for any day in a month, he is eligible for the full calendar month, except for Medically Needy. Medicaid eligibility in the Medically Needy Program is determined by the day the individual meets their share of cost.

2040.0812.02 Requirements for Retroactive Coverage (MSSI, SFP)

The following requirements must be met in order to be eligible for retroactive Medicaid ~~(RMAO)~~:

1. The individual must file an application for ongoing assistance. A request ~~for~~ ~~RMAO~~ can be made for a deceased individual.
2. In the retroactive period, the individual must have received medical services which would be reimbursable by Medicaid. The individual's statement that he has unpaid medical bills for any of the three ~~RMAO~~ months will be accepted; the individual is not required to verify that the bills exist or that the services will be covered by Medicaid.
3. The eligibility specialist will determine eligibility for each of the retroactive month(s) using eligibility criteria for any Medicaid coverage group, regardless of the program for which the individual applied.
4. A determination of eligibility must be made for each of the month(s) in the ~~RMAO~~ period.
5. Once current income has been verified and any discrepancies resolved, staff must accept self-attestation that the individual's income was consistent during the retroactive period. Request additional information only if the income is inconsistent or information known to the agency suggests the individual's circumstance may have changed in the retroactive period.

All SSI-Related noninstitutionalized applications for retroactive Medicaid due to a disability must have the disability reviewed by the Division of Disability Determinations (DDD).

All SSI-Related institutionalized applications for retroactive Medicaid (i.e., ICP and HCBS) due to a disability must have the disability reviewed by the District Medical Review Team (DMRT).

For disability cases, the eligibility specialist should call DDD for a Title II diary date and onset date prior to completing the disability forms. If the retroactive Medicaid date is covered by the Title II onset date, then DDD will adopt the decision and completion of the disability forms will not be necessary. (Also see Chapter 1400, Blindness/Disability Determinations.)

Note: There is no retroactive Medicaid coverage for QMB. For the State Funded Programs (SFP), there is no retroactive coverage. This includes OSS and HCDA.

2040.0815.02 Additional Criteria - HCBS Cystic Fibrosis Waiver (MSSI)

For the Cystic Fibrosis Waiver, individuals must:

1. be at least 18 years of age~~, but no older than 59~~ or older (must meet disability criteria if under age 65);
2. meet a level of care for being at risk of hospitalization as determined by CARES;
3. have a diagnosis of cystic fibrosis and a need for medically necessary services provided by the waiver as determined by Adult Services; and
4. be enrolled in the Cystic Fibrosis waiver as documented by form CF-ES 2515.

2050.0800 RETROACTIVE MEDICAID (CIC)

The following passages will discuss Retroactive Medicaid requirements and the date of entitlement for Retroactive Medicaid.

2050.0812.01 Retroactive Medicaid (CIC)

DCF may authorize Medicaid coverage for any one or more of the three calendar months preceding the month of application for ongoing Medicaid benefits when the requirements are met.

2050.0812.02 Requirements for Retroactive Coverage (CIC)

The following requirements must be met in order to be eligible for retroactive Medicaid:

1. The individual must file an application for ongoing assistance. A request can be made for a deceased individual.
2. In the retroactive period, the individual must have received medical services which would be reimbursable by Medicaid. The individual's statement that he has unpaid medical bills for any of the three months will be accepted; the individual is not required to verify that the bills exist or that the services will be covered by Medicaid.
3. The eligibility specialist will determine eligibility for each of the retroactive month(s) using eligibility criteria for any Medicaid coverage group, regardless of the program for which the individual applied.
4. A determination of eligibility must be made for each of the month(s) in the period.
5. Once current income has been verified and any discrepancies resolved, staff must accept self-attestation that the individual's income was consistent during the retroactive period. Request additional information only if the income is inconsistent or information known to the agency suggests the individual's circumstance may have changed in the retroactive period.

2050.0812.03 Date of Entitlement for Retroactive Medicaid (CIC)

The period of entitlement for each retroactive month is the calendar month for which eligibility is established; that is, if the individual is determined to be eligible for any day in a month, he is eligible for the full calendar month, except for Medically Needy. Medicaid eligibility in the Medically Needy Program is determined by the day the individual meets their share of cost.

2210.0317.03 Residents of Drug and Alcohol Treatment Facilities (FS)

Drug and alcohol treatment facilities applying for food stamps for residents will be required to provide verification they are authorized by FNS as a retailer or are licensed by the Substance Abuse and Mental Health Program, or if unlicensed meet the licensing criteria. They may either provide a copy of their license granted by the Substance Abuse and Mental Health Program, or a letter from the Substance Abuse and Mental Health Program (on ADM letterhead) stating the facility meets the criteria to obtain a license and funding, even though they choose not to be licensed or receive funding.

The eligibility specialist must verify the treatment program is a publicly operated or a private non-profit program. If the nonprofit status was established during the licensing process, the statement of the licensing agency can be considered proof of nonprofit status. If the licensing agency has not made a nonprofit determination for the treatment program, IRS proof of nonprofit status will be required unless the treatment program is operated by a religious group or organization. Since religious groups and organizations are assumed to be nonprofit, a statement from the minister or a member of the board of the organization is sufficient proof of nonprofit status.

By the seventh of each calendar month each treatment and rehabilitation center shall provide DCF with a copy of the residential treatment facility food stamp certification form (CF-ES 2318), listing current residents who are receiving substance abuse services. When a resident leaves the facility, each treatment and rehabilitation center must notify DCF within 5 days by sending a completed change report form informing the agency of the resident's change in address, new address if available, and that the facility is no longer the authorized representative. In addition, the facility must provide the resident with a change report form to be returned to DCF within 10 days noting any changes the resident is required to report. ~~The report must also list any residents who are no longer receiving services, or have been discharged by the facility.~~ The certification form must be signed by the facility director. To ensure the accuracy of the reporting, each Region or Circuit will conduct an on-site review annually. If any discrepancies are discovered, a follow-up review must be conducted within three months.

For simplified reporting AGs, consider information from the facility as verified upon receipt when the Department is notified that a resident no longer resides there. Close the AG if the new address is not known. If the address is known, change the address, remove the authorized representative and keep the case open.

2210.0318.03 Residents of Group Living Arrangements (FS)

Department of Children and Family (DCF) responsibilities include the following:

1. Prior to approving any residents, DCF will verify that the group living arrangement is a nonprofit organization and is certified by DCF. It is not required

that the facility be authorized by FNS. However, if authorization as a retailer has been granted by FNS, this is sufficient evidence of certification and non-profit status.

2. DCF will approve the SFU in accordance with ongoing policy, with only the exceptions outlined in this subsection.

3. Group living facilities are to provide DCF with a list of all current residents by the seventh of each month. This list will include a statement signed by a responsible center official attesting to the validity of the list. When a resident leaves the facility, each treatment and rehabilitation center must notify DCF within 5 days by sending a completed change report form informing the agency of the resident's change in address, new address if available, and that the facility is no longer the authorized representative. In addition, the facility must provide the resident with a change report form to be returned to DCF within 10 days noting any changes the resident is required to report.

   For simplified reporting AGs, consider information from the facility as verified upon receipt when the Department is notified that a resident no longer resides there. Close the AG if the new address is not known. If the address is known, change the address, remove the authorized representative and keep the case open.

Each Region or Circuit will conduct annual on-site visits to the center to assure the accuracy of the listings and that the local office's records are consistent and up-to-date. If any discrepancies are discovered, a follow-up review must be conducted within three months.

2430.0201 Budget Period (MFAM)

Eligibility is based on the standard filing unit composition, technical factors and income circumstances as they exist within the period for which benefits are being calculated. When budgeting for a future month, the estimated anticipated income and circumstances may be based on what occurred in prior months if those months are considered representative of the standard filing unit's continued situation. Budgeting may also be based on the amount the individual can anticipate to receive. ~~When a budget is completed for a month that has already passed, the actual income and circumstances are used.~~

2440.0201 Prospective Budgeting (MSSI, SFP)

Prospective budgeting is a method by which eligibility and benefit levels are based on the assistance group's composition and income circumstances as they exist in the month for which benefits are being calculated. This can be either a past, current or future month. When budgeting prospectively for a future month, the estimated

anticipated income and circumstances may be based on what occurred in prior months if those months are considered representative of the assistance group's continued situation. Prospective budgeting may also be based on the amount the individual can anticipate to receive. ~~When a budget is completed for a month that has already passed, the actual income and circumstances are used. A past month is defined as any month prior to the month of the interview.~~ All assistance groups are subject to prospective budgeting.

2450.0201 Budgeting Period (CIC)

Eligibility is based on the assistance group's composition, technical factors, and income circumstances as they exist in the month for which benefits are being calculated. This can be either a past, current or future month. When budgeting for a future month, the estimated anticipated income and circumstances may be based on what occurred in prior months if those months are considered representative of the assistance group's continued situation. Budgeting may also be based on the amount the individual can anticipate to receive. ~~When a budget is completed for a month that has already passed, the actual income and circumstances are used.~~

2640.0118 Personal Needs Allowance (MSSI)

The amount of the individual's income which is designated as a personal needs allowance (PNA) varies by program.

For ICP and Institutionalized MEDS-AD, the personal needs allowance is $105 as follows:

1. If the individual has less than $105 total countable income, a supplemental payment must be authorized through the Supplemental Payment System (SPS). The personal needs allowance supplement (PNAS) cannot exceed $75 a month.

2. Single veterans (and surviving spouses) in nursing homes who receive a VA $90 pension (disregarded as income in both eligibility and patient responsibility computations) are also entitled to the $105 PNA.

3. Single veterans (and surviving spouses) with no dependents who reside in state Veterans Administration nursing homes may keep $90 of their veterans payments, including payments received for aid and attendance and unreimbursed medical expenses, for their personal needs. Any amount exceeding $90 will be part of their patient responsibility to the facility. These individuals are also entitled to the $105 PNA.

For Community Hospice, the PNA is equal to the Federal Poverty Level.

For Institutionalized Hospice, the PNA is $105. If the individual has less than $105 total countable income, a supplemental payment must be authorized through the SPS. The PNAS cannot exceed $75 per month.

For the Cystic Fibrosis, and iBudget Florida waivers, the PNA is equal to 300% of the federal benefit rate. Because the PNA is the same as the HCBS income limit, only those individuals who become eligible using an income trust will have a patient responsibility.

For the Statewide Medicaid Managed Long-Term Care (SMMC LTC) program and the Program for All-Inclusive Care for the Elderly (PACE), the personal needs allowance is as follows:

1. For an individual residing in the community (not an ALF), the PNA is 300% of the Federal Benefit Rate.

2. For an individual residing in an ALF, the PNA is computed using the ALF basic monthly rate (three meals per day and a semi-private room), plus 20% of the Federal Poverty Level. The ALF basic monthly rate will vary depending on the facility's actual room and board charges.

3. For an individual residing in a nursing home, the PNA is $105.

For the Familial Dysautonomia Waiver the personal needs allowance is equal to the individual's gross income, including amounts that may be placed in an income trust.

For individuals in institutional care who earn therapeutic wages, an additional amount equal to one half of the therapeutic wages, up to $111, can be deducted or protected for personal needs. The total amount of income to be protected as therapeutic wages cannot exceed $111. (This is in addition to the $105 personal needs allowance~~.~~).

For individuals in institutional care who have a court order to pay child support, an additional PNA equal to the court-ordered child support amount be deducted for personal needs. (This is in addition to the $105 personal needs allowance~~.~~).

3210.0101 Authorized Representative/Secondary Cardholder (FS)

When the payee, spouse, or a responsible assistance group member cannot apply for benefits they may be eligible for, an authorized representative may be designated to make application or carry out household responsibilities such as reporting changes or completing work registration on behalf of the assistance group. Food stamp authorized representatives may be designated by the primary payee of an assistance group as a secondary cardholder to receive an Electronic Benefits Transfer (EBT) card and to be able to access the primary payee's food stamp account.

Authorized representatives/secondary cardholders must be designated according to the following requirements:

1. the authorized representative/secondary cardholder must be designated in writing by the payee, spouse, or another responsible member of the assistance group;
2. the authorized representative/secondary cardholder should generally be designated prior to determining eligibility of the assistance group, however, the assistance group can also name an authorized representative/secondary cardholder at any time during the certification period;
3. the authorized representative/secondary cardholder must be an individual who is familiar with the current circumstances of the assistance group; and
4. if it becomes obvious that the authorized representative/secondary cardholder is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group designate another authorized representative/secondary cardholder.

The authorized representative/secondary cardholder may be:

1. authorized on the application;
2. designated in writing using the form CF-ES 3010, Authorized Representative Form; or
3. designated for the interview only or the interview, receipt, and use of food stamps.

Designations of authorized representatives/secondary cardholders are valid for the current certification period only.

Payees of assistance groups who are not able to shop for themselves should be encouraged to designate a food stamp authorized representative as a secondary cardholder for benefit usage.

To ensure recipient understanding of the changes associated with EBT, the following must be discussed with recipients at application and at each review:

1. Recipients may continue to designate authorized representatives to apply and be interviewed on their behalf.
2. Recipients may continue to designate authorized representatives, when appropriate, to receive and use benefits in addition to the recipient's own benefit access.

3. Recipients may designate only one secondary cardholder per assistance group. FLORIDA accepts one secondary payee per payee type.
4. Food stamp authorized representatives will receive a separate EBT card with their name on it. They must select their own personal identification number (PIN).
5. The food stamp authorized representative will have access to all the food stamps in the EBT food account.
6. If a primary payee for both a cash and food stamp assistance group has the same person designated as both the food stamp authorized representative and cash alternate payee, that person will be issued two EBT cards; one to access the food stamp benefit account, and one to access the cash benefit account.
7. EBT benefits are not replaced if they are lost, stolen or misused, including misuse by an authorized representative. Refer to 3210.0217 for more information on stolen benefits.
8. The secondary cardholder's EBT cards are mailed to the primary cardholder.

Note: The applicant can authorize a representative on their application, but form CF-ES- 3010 or a written request must be completed when designating the representative to respond on their behalf.

3210.0111.02 Return of FS Benefits When Resident Leaves Facility (FS)

Once the individual leaves the facility, the facility is no longer allowed to act as that individual's authorized representative or secondary cardholder. This applies to both drug and alcohol treatment centers and group homes for the blind/disabled. Remove the facility's authorized representative on FLORIDA immediately, unless the facility needs the authorized representative's card to return unused benefits or a refund to the customer. Once the process to return the benefits or the refund is complete, remove the drug and alcohol treatment center or group home authorized representative as soon as possible.

Electronic Benefits Transfer (EBT) cards being held by the facility must be returned to the individual within 5 days of the individual's departure from ~~when they leave~~ the facility. If the resident leaves without obtaining the EBT card, the center is to return the card within 5 calendar days to FIS Fidelity National Information Systems at the address below. These cards will have their status changed to "62" (card returned - other), which will deactivate the card(s). Should a resident later inquire about accessing their benefits, they should be referred to EBT Customer Service to request a replacement card.

Mailing address:

ACCESS EBT Card
P.O. Box 290

Milwaukee, WI. 53201-0290

The facility must return a prorated amount of the monthly allotment back to the individual's EBT account based on the number of days in the month the individual resided at the facility. ~~At a minimum, the facility must return one-half of the benefit allotment to the individual regardless of what has been spent when the individual departs prior to the 16th of the month.~~ If the facility did not spend any benefits on behalf of the individual, the facility must return the full value of any benefits already debited from the individual's current monthly allotment back into their EBT account at the time the individual leaves the facility.

The facility must not debit accounts under any circumstances after the individual has left the facility. For example: If there is a delay in the facility receiving the EBT card, and the individual has left the facility when the card arrives, the facility may not swipe the card for payment for meals eaten while the individual was at the facility. The facility must notify the Department when the individual leaves the facility. Benefits are returned to the individual's account by the facility performing a food stamp credit (or refund) transaction.

3220.0101 Authorized Representative/Secondary Cardholder (TCA)

When the payee, spouse, or a responsible assistance group member cannot apply for benefits they may be eligible for, an authorized representative may be designated to make application on behalf of the assistance group. An authorized representative must be designated when food stamps and Temporary Cash Assistance (TCA) are continued for children under age 16 in a TCA food stamp assistance group penalized for noncompliance with work activities. Cash alternate payees may be designated by the primary payee of an assistance group as a secondary cardholder to receive an Electronic Benefits Transfer (EBT) card and to be able to access the primary payee's cash account.

Authorized representatives/secondary cardholders must be designated according to the following requirements:

1. the authorized representative/secondary cardholder must be designated in writing by the payee, spouse, or another responsible member of the assistance group;
2. the authorized representative/secondary cardholder should generally be designated prior to determining eligibility of the assistance group, however, the assistance group can also name an authorized representative/secondary cardholder at any time during the review period;
3. the authorized representative/secondary cardholder must be an individual who is familiar with the current circumstances of the assistance group; and

4. if it becomes obvious that the authorized representative/secondary cardholder is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group designate another authorized representative/secondary cardholder.

The authorized representative/secondary cardholder may be:

1. authorized on the application;
2. designated in writing using the form CF-ES 3010, Authorized Representative Form; or
3. designated for the interview only or the interview, receipt, and use of cash benefits.

Designations of authorized representatives/secondary cardholders are valid for the current review period only.

Payees of assistance groups who are not able to shop for themselves should be encouraged to designate a cash alternate payee as a secondary cardholder for benefit usage.

To ensure recipient understanding of the changes associated with EBT, the following must be discussed with recipients at application and at each review:

1. Recipients may continue to designate authorized representatives to apply and be interviewed on their behalf.
2. Recipients may continue to designate cash alternate payees, when appropriate, to receive and use benefits in addition to the recipient's own benefit access.
3. Recipients may designate only one secondary cardholder per assistance group. FLORIDA accepts one secondary payee per payee type.
4. Cash alternate payees will receive a separate EBT card with their name on it. They must select their own personal identification number (PIN).
5. The cash alternate payee will have access to all the cash in the EBT cash account.
6. If a primary payee for both a cash and food stamp assistance group has the same person designated as both the food stamp authorized representative and cash alternate payee, that person will be issued two EBT cards; one to access the food stamp benefit account, and one to access the cash benefit account.
7. EBT benefits are not replaced if they are lost, stolen or misused, including misuse by a cash alternate payee. Refer to 3220.0217 for more information on stolen benefits.
8. The secondary cardholder’s EBT cards are mailed to the primary cardholder.

Note: The applicant can authorize a representative on their application, but form CF-ES- 3010 or a written request must be completed when designating the representative to respond on their behalf.

3230.0102 Designated Representative (MFAM)

When the applicant/recipient, their spouse, legal guardian, Power of Attorney, or a responsible member of the assistance group cannot apply for benefits they may be eligible for, a designated representative may be authorized to make application on behalf of the assistance group.

Designated representatives must be authorized according to the following requirements:

1. the designated representative must be authorized in writing by the applicant/recipient, their spouse, legal guardian, Power of Attorney, or another responsible member of the assistance group;
2. the designated representative is commonly authorized prior to determining eligibility of the assistance group, however, the assistance group can also name the representative at any time during the review period;
3. the designated representative must be an individual who is familiar with the current circumstances of the assistance group; and
4. if it becomes obvious that the designated representative is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group authorized another representative.

The designated representative may be:

1. authorized on the application, or
2. on any written and signed statement from the applicant/recipient.

~~Authorizations of designated representatives are valid for the current review period only.~~

Recipients may continue to authorize designated representatives to apply and be interviewed on their behalf.

3240.0115 Designated Representative (MSSI, SFP)

A designated representative is someone who assumes responsibility for acting on behalf of the individual or assistance group by providing information for the eligibility determination.

Designated representatives must be authorized according to the following requirements:

1. the designated representative must be authorized in writing by the applicant/recipient, their spouse, legal guardian, Power of Attorney, or another responsible member of the assistance group;
2. the designated representative is commonly authorized prior to determining eligibility of the assistance group, however, the assistance group can also name the representative at any time during the review period;
3. the designated representative must be an individual who is familiar with the current circumstances of the assistance group; and
4. if it becomes obvious that the designated representative is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group authorized another representative.

The designated representative may be:

1. authorized on the application, or
2. on any written and signed statement from the applicant/recipient.

~~Authorizations of designated representatives are valid for the current review period only.~~

The individual can select the designated representative, or if the individual is incapable of selecting a representative, the designated representative may be self-appointed. An organization cannot self-designate, but an individual employee of an organization may continue to self-designate. If the individual employee of an organization self-designates, the preferred method is to complete the CF-ES 2505 form. If this is done, only that employee may communicate with the Department and not any other employee of the organization. If the individual does not designate the designated representative, the eligibility specialist must record the reason.

A designated representative must be selected when the individual has been declared legally incompetent and cannot legally act on his own behalf. If the individual has a legal guardian, the legal guardian must act on the individual's behalf as the designated representative. If the legal guardian will not cooperate or cannot be located, someone else may act as designated representative. When someone other than the legal guardian is the designated representative, a written notice must be sent to the legal guardian advising the legal guardian that a designated representative has been appointed. A copy of the written notice must be filed in the case record.

The individual may select a designated representative at any time. The individual does not have to be functionally or legally incompetent to have a designated representative.

3260.0101 Authorized Representative/Secondary Cardholder (RAP)

When the payee, spouse, or a responsible assistance group member cannot apply for benefits they may be eligible for, an authorized representative may be designated to make application on behalf of the assistance group. An authorized representative must be designated when food stamps and cash are continued for children under age 16 in a cash food stamp assistance group penalized for noncompliance with cash work activities. Cash alternate payees may be designated by the primary payee of an assistance group as a secondary cardholder to receive an Electronic Benefits Transfer (EBT) card and to be able to access the primary payee's cash account.

Authorized representatives/secondary cardholders must be designated according to the following requirements:

1. the authorized representative/secondary cardholder must be designated in writing by the payee, spouse, or another responsible member of the assistance group;
2. the authorized representative/secondary cardholder should generally be designated prior to determining eligibility of the assistance group, however, the assistance group can also name an authorized representative/secondary cardholder at any time during the review period;
3. the authorized representative/secondary cardholder must be an individual who is familiar with the current circumstances of the assistance group; and
4. if it becomes obvious that the authorized representative/secondary cardholder is not aware of the current assistance group circumstances, the eligibility specialist must record this information and immediately request in writing that the assistance group designate another authorized representative/secondary cardholder.

The authorized representative/secondary cardholder may be:

1. authorized on the application;
2. designated in writing using the form CF-ES 3010, Authorized Representative Form; or
3. designated for the interview only or the interview, receipt, and use of cash benefits.

Designations of authorized representatives/secondary cardholders are valid for the current review period only.

Payees of assistance groups who are not able to shop for themselves should be encouraged to designate a cash alternate payee as a secondary cardholder for benefit usage.

To ensure recipient understanding of the changes associated with EBT, the following must be discussed with recipients at application and at each review:

1. Recipients may continue to designate authorized representatives to apply and be interviewed on their behalf.
2. Recipients may continue to designate cash alternate payees, when appropriate, to receive and use benefits in addition to the recipient's own benefit access.
3. Recipients may designate only one secondary cardholder per assistance group. FLORIDA accepts one secondary payee per payee type.
4. Cash alternate payees will receive a separate EBT card with their name on it. They must select their own personal identification number (PIN).
5. The cash alternate payee will have access to all the cash in the EBT cash account.
6. If a primary payee for both a cash and food stamp assistance group has the same person designated as both the food stamp authorized representative and cash alternate payee, that person will be issued two EBT cards; one to access the food stamp benefit account, and one to access the cash benefit account.
7. EBT benefits are not replaced if they are lost, stolen or misused, including misuse by a cash alternate payee. Refer to 3260.0217 for more information on stolen benefits.
8. The secondary cardholder's EBT cards are mailed to the primary cardholder.

Note: The applicant can authorize a representative on their application, but form CF-ES- 3010 or a written request must be completed when designating the representative to respond on their behalf.